SACRAMENTO STATE
Student Health and Counseling Services

AMA Form

WAIVER OF RESPONSIBILITY FOR ACTION AGAINST MEDICAL ADVICE

Patient Name: _____ Date: _____

Date of Birth: _____

INSTRUCTIONS:
PLEASE PRINT EXCEPT FOR INDICATED SIGNATURES.
WITNESS SIGNATURES MUST NOT BE THE RECOMMENDING MEDICAL PROVIDER.

PROVIDER STATEMENT:

I, _____ , have advised _____

That he/she should:

I have identified and discussed with the patient the following benefit(s) and risk(s) of the above recommendation(s) as:

I have identified and discussed with the patient the following risk(s) of NOT accepting the above recommendation(s):

Signed: _____ Date: _____

Witness: _____ Date: _____

PATIENT STATEMENT:

My health-care provider has recommended that I: _____
(Please print)

I understand the nature of my condition and the reasoning behind my provider's recommendation(s). I do not wish to accept the recommendation(s) and I am choosing to proceed against medical advice. I understand that I have been informed of the risk(s) involved and hereby release the directing medical personnel and/or California State University, Sacramento from all responsibility and any ill effects that may result from my actions.

I hereby release California State University, Sacramento and Student Health Services, their employees, volunteers and administrative staff from any and all medical and legal liability resulting from my refusal of treatment as outlined and/or transportation to the nearest appropriate medical facility.

I am 18 years or older, I have read this document and I am signing it freely.

Signed: _____ Date: _____

Witness: _____ Date: _____