Informed Refusal Form

Patient Name: ______________________________ Date of Birth: _______________

Compassionate Family Medicine (CFM), in an effort to obtain the most comprehensive information pertaining to my demographics, medications, health history, family history, etc., has provided me with a Patient Intake Form for me to complete. CFM has explained to me the valuable information this information provides my healthcare team and how this information will assist my team with my medical care.

By signing this Informed Refusal, I am acknowledging that I have refused to complete the Patient Intake Form despite the valuable information it will provide to CFM and my healthcare team and I accept the risk this might pose to my healthcare team by not having my comprehensive medical background available to them.

I fully understand that this Informed Refusal Form will become part of my medical record.

____ ________________________

Patient Signature Date

____ ________________________

Witness Date

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