University of Michigan Hospitals and Health Centers
PATIENT'S RELEASE FORM FOR REFUSAL OF BLOOD OR TREATMENT

I, ______________________________, refuse to allow anyone to

(patient's name)

_______________________________________________________________________
(here insert prohibitions)

The risks attendant to my refusal have been explained to me, and I understand that I will
in all probability need ____________________________________________________

_______________________________________________________________________
(here insert needs)

and that if the same is not done, my chances for regaining normal health are seriously
reduced, and that, in all probability, my refusal of such treatment or procedure will
seriously inperil my life.

I release the Hospital, its personnel and other persons participating in my care from any
responsibility for respecting and following my express wishes and directions.

___________________________________      __________________________________
(witness)       (patient's signature)

_______________________________ a.m. p.m.
(date) (time)

Because the above patient is an unemancipated minor, _________ years of age, this
release is given on the patient's behalf by:

__________________________________ __________________________________
(witness)        (parent or guardian)

_______________________________ ________________________________
(a.m. p.m.)
(date) (time)    (parent or guardian)