San Benito County Emergency Medical Services
Release of Responsibility

Date: ____/____/____ PCR #______________ Agency/Unit #: ______________

I, the undersigned,

- ☐ Do not believe a medical emergency exists; I request no further assistance; **and; I request to be released.**
- ☐ Refuse medical care and/or advice that has been offered by the emergency medical services personnel.
- ☐ Refuse further medical treatment and I fully understand only emergency treatment has been rendered.
- ☐ Will allow only limited medical treatment while enroute to the hospital via ambulance.

SECTION I – RELEASE AT SCENE (RAS)

I understand that any evaluation and/or first-aid type treatment I may have received by emergency personnel is not intended to be a substitute for a complete medical assessment and/or care. The decision & request to emergency services medical personnel not to accept further care and/or transportation to a hospital emergency room has been made by me alone with the understanding that I may still experience a medical complication which remains unknown or unforeseen at this time. Relative to my decision today, I understand that if I change my mind or my condition becomes worse, I can contact 9-1-1 (Emergency Medical Services System).

Patient Name (Signature) ________________ Patient Name (Print) ________________

Parent/Agent Name (Signature) ________________ Parent/Agent Name (Print) ________________

Paramedic/EMT Name (Signature) ________________ Paramedic/EMT Name (Print) ________________

Witness Name (Signature) ________________ Witness Name (Print) ________________

SECTION II – REFUSAL OF CARE /TREATMENT /TRANSPORTATION /AGAINST MEDICAL ADVICE (AMA)

I refuse medical treatment and/or transportation against the medical advice of Paramedic/EMT(s)________________

________________. I acknowledge that I have been informed of and understand the risks and consequences involved with this refusal, to include but not limited to the following:

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Knowing this information, I hereby release the EMS personnel present, and the agency they represent, as well as any Base Hospital involved in this incident, from any and all responsibilities or any ill effects that may result from my decision. I also understand that if I change my mind or my condition becomes worse, I can contact 9-1-1 (Emergency Medical Services System).

Patient Name (Signature) ________________ Patient Name (Print) ________________

Parent/Agent Name (Signature) ________________ Parent/Agent Name (Print) ________________

Paramedic/EMT Name (Signature) ________________ Paramedic/EMT Name (Print) ________________

Witness Name (Signature) ________________ Witness Name (Print) ________________

SECTION III – PRIVACY NOTICE

I acknowledge that the agency named above provided me with, or a reasonable attempt was made to provide me with, a Notice of Privacy Practices and my rights in accordance with the Health Insurance Portability and Accountability Act of 1996, also known as HIPAA.

Name (Signature) ________________ Name (Print) ________________

Comments:

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