GULF COAST MEDICAL CARE PLLC

PATIENT REFUSAL OF TREATMENT

Patient Name: ______________________ Date of Birth: _________ Today's Date: _______

I, ____,

refuse to allow anyone to administer to me:

{ } PAP { } Complete Physical { } Rectal Exam { } Pelvic Exam

{ } Mammogram { } Breast Exam { } Colonoscopy

Other ____

Potential risks have been fully explained to me by Jacques Aristilde, M.D.

I understand that in my physician's best medical judgment, my refusal may result in the need for further treatment; that my chances for regaining normal health may be seriously reduced; or that refusal for such treatment or procedure may seriously imperil my life.

I hereby for myself, my heirs, executors and successors, release Jacques Aristilde, M.D. and staff, including but not limited to any and all physicians in any way connected with me as a patient from any and all liability, claims, suit, cause of action, which might arise or could arise out of the aforesaid parties respecting and following my express wish and direction.

____________________________________ ____________________________________

Patient's Signature Date Signed

____________________________________ ____________________________________

Physician's Signature Date Signed

______________________________________ ____________________________________

Witness' Signature Date Signed