INFORMED REFUSAL

NORTH DAKOTA DEPARTMENT OF HEALTH
COMMUNITY AND HEALTH SYSTEMS
SFN 52519 (4-2022)

Date	Agency		
Name of Client			Date of Birth
Address	City	State	ZIP Code
Reason for Referral/Recommended Diagnostic Follow-Up or Treatment			

Name of Individual that Referred/Recommended Diagnostic Follow-Up or Treatment

I have been advised to seek referral/recommended diagnostic follow-up or treatment because of the above-mentioned reason(s). I acknowledge that the possible risks of not accepting or acting upon the referral/recommended diagnostic follow-up or treatment have been explained to me. Even though it has been recommended that I do so, I do not plan to get referral/recommended diagnostic follow-up or treatment.

Reason(s) for Not Seeking Referred/Recommended Diagnostic Follow-Up or Treatment

I hereby release *Women's Way* and the following organization (release statement) from any and all liability arising out of or connected with my decision not to follow the above medical recommendation.

Organization

Women's Way Client Signature	Date
Witness Signature	Date
Relationship to *Women's Way* Client	

For Office Use Only

Name of *Women's Way* Local Coordinator	Local Coordinating Unit

I verify that the above stated information was provided to the following *Women's Way* client and that she refused to sign this Informed Refusal form.

Women's Way Client

Women's Way Local Coordinator Signature	Date