



INFORMED REFUSAL

NORTH DAKOTA DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH PROMOTION & CHRONIC DISEASE PREVENTION
SFN 52519 (2-2023)

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

Organization(s)

<i>Women's Way</i> Client Signature	Date
Witness Signature	Date
Relationship to <i>Women's Way</i> Client	

For Office Use Only

Name of <i>Women's Way</i> Local Coordinator	Local Coordinating Unit
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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.

<i>Women's Way</i> Client

<i>Women's Way</i> Local Coordinator Signature	Date
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