

Williamson County EMS Mobile Healthcare
COMMUNITY HEALTH PROGRAM (CHP)

**REFUSAL OF MEDICAL CARE
ACKNOWLEDGEMENT**

I, _____, acknowledge that I have been offered services under the Williamson County EMS
Print Name
Community Health Program (Williamson County EMS CHP) and hereby acknowledge my refusal of medical/health care, treatment, and/or services under this program.

I further acknowledge that I have been informed of the risks involved as a consequence of my refusal, and on behalf of myself, my family, heirs, and personal representatives, I release Williamson County and Williamson County EMS, its participating providers, municipalities, officers, representatives, independent contractors, agents, and employees from all present and future responsibility, liability, claims, demands, actions, and causes of action whatsoever, whether known or unknown, foreseeable or unforeseeable, arising out of or related to any loss, damage, expense, illness, injury or aggravation of illness or injury (including death) that I may sustain or incur as a direct or indirect result of my refusal of medical/health care, treatment and/or services under the Williamson County EMS CHP.

I agree that the laws of the State of Texas govern this Refusal, and the venue for any legal proceeding that may arise concerning my refusal of medical treatment is Williamson County, Texas.

PRIVACY NOTICE

We keep a record of the health care services we provide you/the patient in either a printed or Electronic Medical Record. You may ask us to see a copy of that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

These consents may be revoked at any time except to the extent already relied upon. Unless earlier revoked by written notice filed with Williamson County EMS, these consents shall expire three years after the date of last treatment.

By signing below, I acknowledge that I have the right to obtain the Williamson County EMS Notice of Privacy Practices. I may obtain a copy from my Community Health Paramedic at time of refusal or online at www.wilco.org/ems.

Patient's Signature Date / /

Print Name DOB / /

Witness Date / /

Print Name

If Patient is under 18 years of age or Patient has been deemed incompetent to make decisions regarding healthcare services, a parent or legal guardian must read this document and complete information below.

Parent/Legal Guardian's Signature Date / / DOB / /

Print Name Relationship _____

(In the event Patient or the Parent/Legal Guardian, if applicable, refuses to sign this form, this fact should be noted on this form and the form placed in Patient's file.)