CALL #:

_____

TELLER COUNTY EMS COUNCIL AGENCY
RELEASE OF CARE

Have the patient INITIAL one of the two options, read the full details of the release of care to the patient/ guardian, and complete all sections including check boxes, signatures, decisionality, and medical direction.

OPTION 1: _____ I have no medical issue or injuries that require evaluation, treatment, or transport by emergency medical services. I am aware that I can contact emergency medical services at any time in the future by calling 9-1-1 for evaluation and treatment if at any time I feel I am medically ill or injured.

OPTION 2: _____ I am refusing further medical assessment, treatment, extrication, or transport.

I am refusing [ ] medical assessment, [ ] medical treatment, [ ] extrication/transport -or- [ ] I have received medical assessment and temporary medical treatment, but decline extrication/transport. (choose any applicable)

I understand the emergency medical services and first responders that assisted me (or my dependent) are trained to various levels of prehospital care. Their care does not substitute evaluation and treatment by further EMS personnel or a physician. This care is meant to be temporary during transport to definitive care. I recognize that I (or my dependent) may have serious injury or illness that could worsen without further care and transport. Furthermore, I recognize the I (or my dependent) may suffer serious temporary or permanent disability or death secondary to my refusal. I understand that I may change my mind at any time and contact 9-1-1 for further medical assessment, care, and transport. The emergency medical services provider completing this form has discussed with me the risks, benefits, and alternatives - as well as the risks and benefits of the alternatives - of my refusal. I fully understand all components discussed. Furthermore, I hereby release emergency medical services and first responders, all of their agents and personnel, and the medical directors associated, from any and all liability secondary to my refusal.

PATIENT NAME: _____ **PATIENT DOB:** _____

RELEASE OF CARE COMPLETED: Date: _____ Time: _____

SIGNATURES: *(ONE witness must sign for all releases of care - it can be another provider present. TWO witness must sign for any patient refusing to sign this form. Document relationship to patient for guardians.)*

Patient/Guardian Name: _____ Signature: _____

Provider Name: _____ Signature: _____

Witness Name: _____ Signature: _____

Witness Name: _____ Signature: _____

DECISIONALITY: *(all components must be met prior to completion of release of care)*

Patient/Guardian is: [ ] able to make decisions, [ ] not clinically intoxicated, and [ ] able to repeat back to you the information discussed in this release of care so that you are comfortable that the patient/guardian is able to weight the risks, benefits, and alternatives.

MEDICAL DIRECTION: *(medical direction only needs to be contacted for uncomfortable releases of care)*

Was medical direction contacted: [ ] Yes [ ] No. ***If yes,*** MD Name: _____