

**MARIN COUNTY EMS
AGAINST MEDICAL ADVICE (AMA)–RELEASE AT SCENE (RAS) FORM**

CRITERIA FOR REFUSING CARE

The patient meets all of the following:

1. Is an adult (18 or over), or if < 18 meets the criteria stated in the AMA/RAS policy
2. Exhibits no evidence of:
 - Altered level of consciousness
 - Alcohol or drug ingestion that impairs judgment
3. Understands the nature of the medical condition, as well as the risks and consequences refusing care

1. ACKNOWLEDGMENT OF INFORMATION:

A. AMA: I have been advised that medical assistance on my behalf is necessary, and that refusal of said assistance could be hazardous to my health, and under certain circumstances, including disability and/or death. I have been advised to discuss my medical complaints with my regular health care provider as soon as possible. Nevertheless, I refuse to accept treatment or transport to a medical facility and assume all risks and consequences of any decision.

or

B. RAS: I acknowledge that I may have a medical problem, which may require additional medical attention, and that an ambulance is available to transport me to the hospital. Instead, I elect to seek alternative medical care and refuse further treatment and/or transport.

2. RELEASE OF LIABILITY: By signing this form, I am releasing the County of Marin, the responding Provider Agency(ies), and the Receiving Hospital (if contacted) of any liability or medical claims resulting from my decision to refuse the medical care/transport offered.

I have read and understand the “Acknowledgment of Information” and “Release of Liability”. I also acknowledge that I have received a Notice of Privacy Practices.

Signature: _____ **Refused to sign, Reason:** _____

Relationship (if not the patient): Lawful: parent guardian conservator (pertains to a child/dependent only)

Physician Consulted: _____

Telephone consent/refusal obtained. Witnessed by: _____

Interpreter used: _____

DISPOSITION:

Released in care or custody of self.

Released in custody of law enforcement

Agency: _____

Badge #: _____

Released in care or custody of:

Parent Guardian

Other: _____

Instructions

1. If you change your mind or your condition changes, call 9-1-1 (in an emergency), go to an emergency department in your area, or call your private doctor (if appropriate).

2. _____

3. _____

Completed by (Print) _____ Signature _____ Unit #/Agency # _____

Witness Information

Signature: _____ Name Printed: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: () _____ Driver's License #: _____

Patient Name: _____ AO#: _____

DDM: _____ Date: _____