Med-Trans Corporation

DBA North Colorado Med Evac

Refusal To Authorize Treatment

The undersigned patient or the patient's lawful surrogate has been advised by_____that it is necessary for the patient to undergo the following treatment while enroute on Med-Trans Corp.

Description_____

_____

The necessity, effect, and nature of the above described treatment has been fully explained to the undersigned and the undersigned understands that failure to follow the advice for treatment recommended above could imperil the patient's life or health. Nevertheless, the undersigned refuses to consent to the recommended treatment and assumes all risks and consequences involved or arising by virtue of non-treatment and release Med-Trans Corp. and Banner Health and their respective agents and employees and the attending or directing physician of any and all liability or claims arising by virtue of non-treatment of the patient's condition.

Date_____ Time_____ Signature of Patient_____

_____ _____

Signature of Lawful Surrogate (if patient is unable to sign) Witness

Refusal To Authorize Transportation

The undersigned has been advised by on-site personnel of Med-Trans and Banner Health that it is medically necessary for the patient to be transported to a health-care facility. The reasons for and the nature of the air transportation and the adverse consequences associated with other transportation requiring longer transport time of the patient to a medical facility have been explained to me and I understand the adverse medical consequences to the patient's life and health that may occur because of refusal of air transport.

Although failure to follow the advice that I have received may seriously impair the patient's life or health, I nevertheless refuse to the recommended mode of air transportation and I assume all risks and consequences involved or that arise by selection of other forms of transportation and release Med-Trans Corp. and Banner Health and their respective agents and employees and the attending physician of and from all liability and causes of action arising by virtue of this refusal.

Date_____ Time_____ Signature of Patient_____