Hospital Disclaimer Form

Patient Name: _____
Date of Birth: _____
Address: _____
Phone Number: _____
Email: _____

I, the undersigned patient or legal guardian of the patient named above, acknowledge and agree to the following terms and conditions:

1. Acknowledgement of Risks:
I understand and acknowledge that medical treatment or procedures involve certain risks, and that despite the efforts of the medical staff, complications may arise.

2. Consent to Treatment:
I authorize the hospital/healthcare institution and its medical staff to conduct necessary medical procedures, treatment, and care deemed appropriate for my condition.

3. Release of Liability:
I release the hospital, its staff, and affiliated healthcare providers from any liability arising from medical treatment, except for instances of proven negligence or malpractice.

4. Privacy and Confidentiality:
I understand that my medical records and information will be kept confidential in accordance with applicable laws and regulations.

5. Responsibilities:
I acknowledge my responsibility to provide accurate information about my health history and follow the instructions provided by the medical staff.

6. Financial Responsibility:
I understand that I am responsible for all charges incurred for services rendered and agree to comply with the hospital's financial policies.

7. Emergency Contact:
I authorize the hospital to contact the listed emergency contact in case of emergencies or when necessary.

I have read and understood the above information. I sign this form voluntarily and without duress.

Patient/Guardian Signature: _____
Date: _____

Witness Signature (if required): _____
Date: _____