



Clínica Especializada de Azuero  
CUIDANDO TU SALUD

Pegar Label Aquí

## ACUERDO DE RELEVO DE RESPONSABILIDAD GENERAL

### 1) PATIENTS INFORMATION

NAME JUAN		LAST NAMES GONZALEZ
DATE OF BIRTH 01/09/1971	PERSONAL I.D./PASSPORT 8-00-678-887-D	GENDER M

### 2) INFORMATION OF PERSON MAKING THE REQUEST (Complete when the person making the request is not the patient)

NAME AND LAST NAMES	PERSONAL I.D./PASSPORT
LINK BETWEEN PERSON MAKING THE REQUEST AND PATIENT <input type="checkbox"/> HUSBAND/WIFE <input type="checkbox"/> SON/DAUGHTER <input type="checkbox"/> LEGAL REPRESENTATIVE	

### 3) RELEASE OF LIABILITY

This agreement releases clínica especializada de azuero of any civil, financial or other type of liability as well as Dr. \_\_\_\_\_ and hospital staff for the injuries that may happen during \_\_\_\_\_ given the serious and unstable condition of the patient and his/her own diagnosis leads to this being the only alternative to any possible treatment.

I acknowledge I have been clearly informed of the risks involved; \_\_\_\_\_, therefore, I assume their consequences. I also accept the physician and hospital staff have explained to me everything related to this situation and I have taken this decision voluntarily, in agreement with the description of the facts.

Situation (describe briefly) \_\_\_\_\_

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Signature of the Patient: \_\_\_\_\_ I.D. \_\_\_\_\_ Date: \_\_\_\_\_ OR

Signature of Family Member in charge \_\_\_\_\_ I.D. \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Physician \_\_\_\_\_ I.D.: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness \_\_\_\_\_ I.D. \_\_\_\_\_ Date: \_\_\_\_\_

(Will sign in absence of physician)