995 Worthington Street, Springfield, MA 01109
Telephone 413-734-5376
FAX 413-737-7949

MEDICAL SERVICES REFUSAL FORM

I, ________________________________, have been offered support and have been encouraged to attend a routine medical examination. I do not wish to have an examination at this time.

Signature of individual: ______________________________ Date: _________________

I, ________________________________, have been offered support to attend a routine dental exam. I do not wish to have a dental exam at this time.

Signature of individual: ________________________________ Date: ________________

I,__________________________________, have been offered support to accept a routine eye exam. I do not wish to have an eye exam at this time.

Signature of individual: ________________________________ Date: ________________

I,__________________________________, do not wish to have any of the medical examiniations suggested about at this time. If I should change my decision, I will contact MHA for support/assistance.

Signature of individual: ________________________________ Date: ________________

Signature of witness to all signatures: _____________________ Date: ________________

***Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. <u>45 C.F.R. 164.508.</u>**