პაციენტის წერილობითი ინფორმირებული უარი სამედიცინო მომსახურების გაგრძელებაზე

Written Informed Refusal of the Patient to Continue Medical Services

2024 წელი

I, ---------- (**Patient** name),

Patient ID: ----------, Case Number ---------- Tel: ----------

By signing this document, I confirm that I have received complete information from the treating physician regarding the nature and necessity of the medical service, the risks and consequences related to this service for my health and life, financial and social issues, as well as the possible consequences of refusing to continue treatment. Based on my free will, I wish to declare my refusal of the proposed treatment. I also confirm that I fully understand the possible illegal consequences of my actions and that I have no claims against "Tbilisi State Medical University and Ingorokva University Clinic of High Medical Technologies." The patient has received answers to all their questions and has been provided with complete information.

Medical doctor: ---------- Signature: ----------

Patient Signature ----------