Waiver of Communication Accessibility Services

Complete this form only if you DO NOT want this healthcare facility to provide free communication accessibility aids and/or services to facilitate communication between you and our staff.

I, _____,

understand that I have the right to be provided with free, appropriate aids and/or services when necessary for effective communication. I do not want aids and/or services provided to me because:

_____

_____

I prefer to communicate using:

_____

_____

I understand that this healthcare facility will not pay for any aids and/or services that I choose to provide *on my own.*

I also understand that I can change my mind at any time and request that this healthcare facility provide aids and/or services at no charge to me.

Patient/Family Member/Companion Signature	Date

Signature of person, if any, who filled out this form on behalf of the patient, family member, or companion:

