IN _____ COUNTY, FLORIDA

*IN THE MATTER OF **NON-CONSENT***
TO REMOVE MY ELDERLY
RELATIVE/FRIEND FOR
PSYCHIATRIC EXAMINATION

NON-CONSENT

1. I, _____, am the medical proxy of the elderly individual subject to this **non-consent** who is:

Current Name	**Gender**	**Birth date**
_____	_____	_____

2. I **do not** relinquish all rights to care for this elderly family member/friend, _____. I can provide an environment for _____ that is not dangerous, and I will prevent _____ from causing serious bodily harm to anyone in the near future. I will provide a safe environment and care for _____, with full knowledge of the legal effect of this **non-consent.**

3. I understand my legal rights as a medical proxy and I understand that I do not have to sign this **non-consent** and **do not** release my rights. I acknowledge that this **non-consent** is being given knowingly, freely, and voluntarily. I further acknowledge that my **non-consent** is not given under fraud or duress. I **do not** give up my rights to and interest in caring for this individual, and this **non-consent** may only be withdrawn if the Court orders it. I **do not** voluntarily relinquish all my rights to this elderly family member/friend, and I give **no permission** for psychiatric examination for any purpose.

4. I **do not** consent, release, and give up permanently, of my own free will, my rights to care for this individual for the purpose of psychiatric examination.

5. I **do not** waive any notice of _____'s removal from my care for the purpose of psychiatric examination. I want to be contacted in the event that involuntary psychiatric examination is being considered.

6. I understand that pursuant to Chapter 394, Florida Statutes, _____ can only be psychiatrically examined if "Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such

harm may be avoided through the help of willing family members or friends or the provision of other services."

7. I am a willing family member/friend, and intend to seek other services if necessary.

I understand that I am swearing or affirming under oath to the truthfulness of the claims made in this non-consent and non-waiver and that the punishment for knowingly making a false statement includes fines and/or imprisonment.

Dated: _____

_____
Name
_____Address
_____, Florida, _____.

Telephone No.: _____

Signature:

_____

STATE OF FLORIDA
COUNTY OF _____

Sworn to or affirmed and signed before me on _____ at _____ a.m./p.m.

_____
NOTARY PUBLIC or DEPUTY CLERK

_____
[Print, type or stamp commissioned name of notary or deputy clerk.]

_____ Personally known
_____ Produced identification
Type of identification produced _____

I hereby acknowledge receipt of a copy or duplicate original of this executed **Consent and Waiver.**

_____
(Signature of nursing home, ALF personnel & Title or Medical professional)