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WAIVER OF INTERPRETER SERVICES

PATIENT NAME: _____

INTERPRETER NAME: _____

I,_____ , understand that under federal law, I have the right to have a qualified medical interpreter provided to me free-of-charge by the University of Colorado School of Medicine (SOM) to explain to me, in my native language, information concerning my medical treatment. I acknowledge that SOM explained this right to me in my native language.

I understand that SOM provides this service free-of-charge for its limited English and non-English speaking patients.

I understand that this service may be provided to me by using an in-person qualified medical interpreter and/or by speaking to a qualified medical interpreter over the telephone or through another device.

SOM has encouraged me to use the services of a qualified medical interpreter provided by SOM. I acknowledge that SOM explained to me in my native language the importance of having medical treatment information explained to me by a qualified interpreter in my native language so that I can understand my medical treatment and fully and knowingly participate in decisions about my medical treatment.

I acknowledge that the staff of SOM discussed with me the risks of using friends or family members as my medical interpreters. These risks, as explained to me by SOM, include but are not limited to the following:

- Family members or friends may not have the bilingual language skills and technical vocabulary required to interpret information completely and accurately concerning my medical treatment,
- Family members or friends may not feel bound to uphold the same standards of privacy, confidentiality, ethics, and linguistic accountability as a professional, qualified, medical interpreter, and,
- Issues may arise concerning my medical treatment that may be sensitive and/or difficult to discuss with me through a family member or friend.

However, I have freely, voluntarily, and knowingly decided to use a friend and/or a family member as interpreters concerning information about my medical treatment. I freely, voluntarily, and knowingly decline the interpreter services that SOM has offered to provide me.

I understand the risks of using my friends and family members as my interpreters. I freely, voluntarily, and knowingly agree to assume these risks.

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I understand that by using friends or family members as my interpreters, confidential information will be disclosed to the friends or family members and I agree that this disclosure can be made.

I understand that by using a friend or family member as my interpreter, my assessment, and/or medical treatment may be delayed if she/he is not present when needed.

I understand that at any time, I can change my mind and ask my medical provider or clinic staff member for an interpreter to be provided by SOM.

I, _____ have read the above and received a copy.

_____ _____

Patient's Signature Date

_____

Patient's Name- Please PRINT