*INSERT NAME OF HEALTHCARE FACILITY*

**WAIVER AND RELEASE OF INTERPRETER SERVICES**

*INSERT NAME OF HEALTHCARE FACILITY* will provide you a qualified interpreter and other auxiliary aids when necessary to allow you access to their services. Such services will be provided with no additional cost to you.

1. *INSERT NAME OF HEALTHCARE FACILITY* staff will provide an interpreter for you through telephone or in person or by Video Remote Interpreting (VRI).
2. You may choose not to use our contracted interpreter. If you choose to use family or a non-contracted interpreter, you release *INSERT NAME OF HEALTHCARE FACILITY* and all its affiliated entities of all liability for interpreting services. There will be no reimbursement paid to your family or the non-contracted interpreter. *INSERT NAME OF HEALTHCARE FACILITY*  will not sign any paperwork presented to them.
3. I understand that the *INSERT NAME OF HEALTHCARE FACILITY* staff will obtain an interpreter to ensure that they are able to effectively communicate with me for key health communications.

**I have chosen not to use an interpreter provided by** *INSERT NAME OF HEALTHCARE FACILITY.* **I have had the opportunity to discuss this with the** *INSERT NAME OF HEALTHCARE FACILITY* **staff. I understand that there may be significant risks to me by not using an interpreter provided by** *INSERT NAME OF HEALTHCARE FACILITY,* **e.g. misinterpretation of critical health care information, breach of confidentiality etc.**

**Patient’s Signature Date**