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Patient Request or Refusal of Interpretive Services

Date: _____

Patient Name: _____

Patient's Primary Language: _____

- Yes, I am requesting interpretive service for language(s) _____

- No, I will use my family and/or friends for interpretive service
 - Yes, family and/or friend is a minor (under age 18)
- No, I do not require interpretive services
- Other: _____

I am aware of the availability of free language assistances services (interpretation and translation), by my health plan. I have completed the above information and understand I can change my preference if needed at any time and will let the clinic know if my preference changes.

Signature: _____

Date: _____