



CAFP-Foundation Interpreter Service Waiver

I, _____, understand that [insert practice name] offers the services of qualified medical interpreters to all limited-English proficient patients, either in person or by telephone. I am declining these services and choosing instead to have an adult friend or family member interpret for me. I acknowledge that [insert practice name] has discussed with me the inherent risks in using friends or family members, including but not limited to:

Family members or friends may not have the language or interpreting skills required to interpret accurately and completely in medical settings;

Family members or friends may not feel bound to uphold the same standards of privacy and confidentiality as a professional interpreter; and

Issues may arise that are sensitive and/or difficult to discuss through a family member or friend.

I voluntarily and knowingly decline the interpreter services [insert practice name] has offered. I understand the potential risks involved and agree to assume those risks. I am choosing to have an adult friend or family member interpret for me.

Patient Name

Witness name

Date

Patient Signature

Witness signature

Date