Patient Notice of Intent

FAX TO ______________________________

ABORTION CLINIC, LAW ENFORCEMENT AGENCY, CHILD PROTECTIVE SERVICES OFFICE, LEGAL COUNSEL, ETC.

ATTN ____________________ **FAX #** ____________________ **DATE** ____________

I am currently pregnant and I am aware that state and federal law allows me to obtain the reproductive healthcare that I believe to be in my best interest, including abortion or prenatal care. I also understand that these laws apply to me even if I am a minor. After having considered my options, I have decided to continue my pregnancy to term. However, I am being subjected to coercion by others that is meant to compel me to terminate my pregnancy against my will.

This document shall serve as notice that if I am brought to a healthcare facility for the purpose of obtaining an abortion, my presence there will be a result of the threats, intimidation, force or threats of force that are being directed at me. Further, it is probable that a person or persons whose objective is to prevent me from either withholding or withdrawing my consent for an abortion will accompany me to this facility. For these reasons, I will not have the ability to either express or act upon my decision not to have an abortion. Therefore, my consent for such a procedure would be involuntary and, thus, legally invalid.

Should an abortion be performed on me under these circumstances, I will seek legal counsel regarding the criminal prosecution and/or civil liability of all participating members of the healthcare facility's medical staff and non-medical support staff for committing and/or conspiring to commit one or more of the following acts: wrongful death; aggravated assault; sexual assault; kidnapping; wrongful imprisonment; injury to a child; child abuse; failure to report suspected child abuse; medical malpractice; failure to obtain informed consent; fraud; misrepresentation; interference with parental relationship; medical license violations; or other related infractions. I am also aware that, regardless of my age or marital status or any other factor, anyone who uses threats, intimidation, force or threats of force to compel me to terminate my pregnancy against my will may be subject to legal action under state and/or federal law including, but not limited to, statutes that relate to fetal homicide.

For my own protection as well as that of my unborn child, by my signature below I give permission for the organization identified herein as the "Pregnancy Center" to immediately forward copies of this document to the following:

[1] every abortion clinic or other abortion provider to which I might be taken;

[2] every law enforcement entity (police department, sheriff's department, district attorney's office, etc.) with jurisdiction where I reside and those with jurisdiction where the abortion might be performed; and

[3] my legal counsel and/or the legal counsel representing the Pregnancy Center.

In addition, if I am a minor, the Pregnancy Center has my permission to provide this document to every city, county or state social service agency responsible for the protection of underage children with jurisdiction where I reside and those with jurisdiction where the abortion might be performed.

____
PATIENT'S NAME (PLEASE PRINT)

______________ ______________________
PATIENT'S DATE OF BIRTH *PATIENT'S DRIVER'S LICENSE OR SS NUMBER*

____
PATIENT'S STREET ADDRESS

____
PATIENT'S CITY, STATE AND ZIP

____
NAME OF PREGNANCY CENTER

____
CITY AND STATE WHERE PREGNANCY CENTER IS LOCATED

____
PREGNANCY CENTER PHONE NUMBER

____
CONTACT PERSON AT PREGNANCY CENTER

I have read and I understand this document. I also affirm that it reflects my true intentions regarding my pregnancy.

PATIENT'S SIGNATURE *DATE*

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