

PATIENT'S NOTICE OF INTENT

I am currently pregnant and I am aware that state and federal law allows me to obtain the healthcare I believe to be in my best interest. I understand this is true even if I am a minor. I plan 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 nonmedical support staff for committing and/or conspiring to commit one or more of the following acts: wrongful death; aggravated assault; false 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 or the Federal Unborn Victims of Violence Act.

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: (a) every abortion clinic or other abortion provider to which I might be taken; (b) every

law enforcement entity (police department, sheriff's department, district attorney's office, etc.) with jurisdiction where I reside as well as those with jurisdiction where the abortion might be performed; (c) my legal counsel and/or the legal counsel representing the Pregnancy Center; and (d) any person the Pregnancy Center believes is involved in my decision-making process including, but not limited to, those who may be trying to force or coerce me to terminate my pregnancy against my will.

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.

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

✓

Patient's Signature

Date