**Waiver Of Medical Treatment Form:**

Offender Name: DOB:

Offender #: Institution:

I have had my medical condition explained to me by:

I understand that I have been diagnosed with:

I understand that the following treatment is recommended:

A health care provider has explained to me the nature of the treatment recommended and the possible adverse consequences that may occur as a result of my refusal. I further understand that, in all probability, refusal of such treatment or procedure may cause chronic aggravation, permanent disability or will seriously imperil my life or may result in my death.

I hereby release the State of Alaska, Department of Corrections, the Superintendent, the institution where I am incarcerated as well as its employees, together with all physicians and medical personnel in any way connected with me as a patient for the above described condition from liability for my refusal to follow their medical-dental-psychiatric recommendations.

I understand I may withdraw this refusal at any time without fear of reprisal.

Health Care Staff Witness: Patient Signature:

Date: Date:

**Patient Refusal to Sign:** Staff shall write “Patient refuses to sign” on the patient signature block and have a second staff member witness the refusal.

Health Care Staff Witness to Refusal: Health Care Staff Witness to Refusal:

Date: Date:

I hereby certify that I have examined this patient and recommend the treatment as outlined above. I find this patient to be mentally competent to make the decision to refuse the recommended treatment; and further, that this patient understands the complications that may result from foregoing such treatment.

Health Care Practitioner : Date: