OKLAHOMA DEPARTMENT OF CORRECTIONS
WAIVER OF TREATMENT/EVALUATION
(Form must be completed in its entirety)

Facility__________________________________________  Date________________  Time_______________________

I certify that I am refusing to consent to the following treatment/procedure/diagnostic test/medication/outside referral/laboratory at my own insistence and against the advice of the health care provider.

1. Refusal for: __________________________________________________________
   __________________________________________________________
   __________________________________________________________

2. Reason for the refusal: ________________________________________________
   __________________________________________________________
   __________________________________________________________

3. I have been informed by a Health Care Provider, RN or LPN of the risks attendant to my refusal. These include:
   __________________________________________________________

4. During the clinical interview which included counseling and education, the Health Care Provider, RN or LPN has given me the opportunity to ask questions and has answered my questions.

5. I assume full responsibility for any results caused by my decision and I hereby release the institution, its employees, officers, and the provider from all legal responsibility and liability.

6. I certify that I am of sound mind and have read, or had read to me, and fully understand the above information concerning my refusal to accept treatment/evaluation and have had an opportunity to ask questions before I affix my signature.

7. I understand I may retract my decision and receive the treatment/procedure/diagnostic test/medication/outside referral/laboratory, although consequences due to the delay may result.

Inmate Signature: ____________________________________________  Date:________________

Health Care Provider/RN/LPN: ____________________________________________  Date:________________

If the refusal is for an outside specialty clinic appointment based on a medical condition preventing travel or a scheduled family visit, does the inmate want the outside specialty clinic appointment rescheduled:  □ Yes  □ No

If the offender refuses to sign such a statement, he/she cannot be forced to do so legally nor may release be withheld until the offender signs. If this occurs, the form should be filled out, witnessed by two facility personnel and the statement documented on the form, “SIGNATURE REFUSED.”

Witness Signature: ____________________________________________  Date:________________

Inmate Name: ____________________________  DOC Number: ____________________________
(Last, First)