OKLAHOMA DEPARTMENT OF CORRECTIONS
CONSENT FOR MEDICAL, DENTAL AND MENTAL HEALTH TREATMENT

Facility: ___________________________ Date: ______________ Time: ___________

I hereby authorize __________________________________ and assistants to perform
(Name of Provider)
the following operation, procedure or treatment:

____________________________________________________________________________________

The nature and the extent of the intended operation, procedure or treatment have been
explained to me in detail.

I have been advised by the above provider of the following alternatives, if any, probable
consequences if I remain untreated, risks and possible complications of proposed
treatment as indicated:

____________________________________________________________________________________

____________________________________________________________________________________

I acknowledge that no guarantee or assurance has been made as to the desired result
that may be obtained.

If any unforeseen condition arises in the course of the operation, procedure or treatment
calling for the judgement of the provider for procedures in addition to or different from
those now contemplated, I further request and authorize the provider to do whatever is
deemed necessary.

I consent to the administration of anesthesia to be applied by or under the direction of
the above named practitioner or his designee, and the use of anesthetics, as he/she
may deem advisable.

Please check one of the boxes below, which describes your situation

☐ I have read and fully understand the terms of this consent and acknowledge that
the explanations referred to were made and that all blanks have been filled.

OR

☐ I do not speak or read English and an interpreter has explained this consent to
me. I fully understand the terms of this consent and acknowledge that the
explanations referred to were made and all blanks have been filled.

Name of Interpreter: ____________________________________

Inmate Signature: ________________________________________ Date: __________

Health Care Provider: ____________________________________ Date: __________

Inmate Name (Last, First)

---

DOC 140701A (R 4/18)