

Informed Waiver of Medical Treatment

I, _____, Date of Birth, _____ OTIS #, _____, have had my physical condition explained to me by _____ and understand that I am suffering from _____ and the following treatment plan will be provided _____

A Health Care Practitioner has explained to me the nature of the treatment, which I hereby do, the complications, and I further understand that, in all probability, by 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 or the institution where I am incarcerated as well as 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 may withdraw this refusal at any time without fear of reprisal.

Witness to Patient's Signature

Patient Signature

Date

Date

Patient Refusal to Sign:

Staff shall write "Patient refuses to sign" and have a second staff member witness the refusal.

Health Care Staff Member

Health Care Staff Member

Date

Date

I hereby certify that I have examined _____ and recommend _____ treatment. I find _____ to be mentally competent to make the decision not to undergo the recommended treatment; and further, that _____ understands the complications that may result from foregoing such treatment.

Health Care Practitioner

Date

Distribution: Prisoner Health Care Record
Major Medical Office