DEPARTMENT OF PUBLIC SAFETY & CORRECTIONAL SERVICES
RELEASE OF RESPONSIBILITY FORM

Incarcerated Individual's Name: _____ Date of Birth: _____

SID #: _____ Sex: ☐ Male ☐ Female Facility: _____

I hereby acknowledge that I have been informed by appropriate healthcare personnel as to my healthcare condition.

(Specify nature of condition)

_____

_____

_____

Against the advice of said healthcare personnel, I refuse to have:

☐ BLOOD DRAWN ☐ PHYSICAL EXAM

☐ MEDICATION ☐ OTHER: _____

I further acknowledge that I have been informed of the risks involved, and accept full responsibility for this action, and hereby release the attending physician and other healthcare services staff from responsibility/liability for any complications or undesirable results arising from my refusing the above stated treatment.

Date _____

Incarcerated Individual's Printed Name: _____

Incarcerated Individual's Signature: _____

Witness #1 Printed Name: _____

Witness #1 Signature: _____

Witness #2 Printed Name: _____

Witness #2 Signature: _____

(A second witness is required if patient refuses to sign release)