MAINE DEPARTMENT OF CORRECTIONS

REFUSAL OF TREATMENT

RESIDENT NAME: MDOC #: DOB:

I am refusing the health care that has been recommended for me, as specified below:

- ☐ Community health care appointment (specify):
- ☐ Dental care (specify):
- ☐ Eye care (specify):
- ☐ Laboratory service (specify):
- ☐ Medication (specify):
- ☐ Physical examination (specify):
- ☐ X-ray services (specify):
- ☐ Other diagnostic test (specify):
- ☐ Other procedure or treatment (specify):

Resident's stated reason for refusal:

Resident informed of risks of refusing the health care (specify risks):

Comments, if any:

I acknowledge that I have been fully informed of and understand the above health care recommendation(s) and the risks involved in refusing. I understand that by refusing health care at this time, I do not necessarily waive my right to subsequently request the recommended treatment or other health care.

I release the Maine Department of Corrections, its contracted health care services provider, their employees, and their agents from any and all liability which may arise from this action.

I have read, or have had read to me, this form and acknowledge that I understand its contents and I am signing it voluntarily.

_____	_____
Resident Signature	Date

_____	_____	_____
Guardian Name (where applicable) (Print)	Guardian Signature	Date

_____	_____	_____
Witness (Print)	Witness Signature	Date

I have explained the matters indicated above relating to the refusal of health care. The resident appeared to understand.

_____	_____	_____
Health Care Provider Name (Print)	Health Care Provider Signature	Date