

**FLORIDA DEPARTMENT OF CORRECTIONS
REFUSAL OF HEALTH CARE SERVICES**

This is to certify that I am refusing the following:

- Medical Services _____
- Mental Health Services _____
- Dental Services _____
- Medication _____
- Lab/Diagnostic testing _____
- Other _____

I understand this refusal is against the advice of my health care providers. I acknowledge that I have been informed of the diagnosis, if known, the nature and purposes of the proposed procedure/treatment/medication, risks and benefits of the proposed procedure/treatment/medication, alternative treatments and their risks and benefits and the consequences and danger to my health and possibly to my life that may result from my refusal of this procedure/treatment/medication.

I have been given time to ask questions about my condition and about my decision to refuse the proposed procedure/treatment/medication that my health care provider has explained to me is medically indicated and necessary.

I voluntarily assume the risks and accept the consequences of my refusal of the procedure/treatment/medication and I am releasing the Department of Corrections, all health care providers, the facility, and facility staff from any and all liability for ill effects that may result from my refusal of treatment.

Signature of Patient*

Date/Time

Two Witnesses: I, _____ am a health care staff member and I have witnessed the patient voluntarily sign this form/refuse to sign the form.

Signature of Witness

Title of Witness

I, _____ am a staff member who is not the patient's health care provider for this procedure and I have witnessed the patient voluntarily sign this form/refuse to sign the form.

Signature of Witness

Title of Witness

I am aware that this patient refused the proposed procedure/ treatment/medication and has signed this form/ refused to sign the form.

Signature of Clinician

Date/Stamp

Interpreter/translator: To the best of my knowledge, the patient understood what was interpreted/translated and voluntarily signed this form/refused to sign the form.

Signature of Interpreter/Translator

Title of Witness

*If the patient refuses to sign this document, but has verbally refused the above procedure, write REFUSES TO SIGN above Signature of Patient.

Inmate Name _____

DC# _____ Race/Sex _____

Date of Birth _____

Institution _____

**ESTADO DE LA FLORIDA DEPARTAMENTO DE CORRECCIONES
DECLARACION JURADA DE RECHAZO A TRATAMIENTO MEDICO**

Yo certifico que rechazo lo siguiente:

- Servicios medicos _____
- Servicios de salud mental _____
- Servicios dentales _____
- Medicamentos _____
- Exámenes de laboratorio/dignostico _____
- Otros _____

Yo comprendo que este rechazo es en contra de la opinion medica. Yo reconosco que he sido informado del diagnostico, si es confirmado, la condicion y proposito del tratamiento o intervencion/ medicamento, consecuencias, los beneficios del tratamiento ntervencion recomendada/ medicamento, tratamiento alterno, consecuencias y peligros para mi salud y posible riesgos de muerte que puede resultar por no consentir a estos servicios de atencion medica.

Se me ha dado suficiente tiempo para hacer preguntas, consecuencias, los beneficios del tratamiento/ intervencion recomendada, se me ha explicado la naturaleza de mi affeccion y he sido informado del riesgo para mi salud. Se me ha explicado y entiendo la necesidad de atencion medica, que es indicada y necesaria.

Yo voluntariamente asumo los riesgos y acepto las consecuencias de mi rechazo a tratamiento medico/ medicamento. Yo declaro, que el medico que me atendio, la institucion, el personal administrativo y el Departamento de Correcciones no son responsables por cualquier incapacidad, complicaciones que puedan ocurrir como consecuencia de haberme negado a recibir tratamiento medico.

Firma del Paciente* _____
Fecha/Hora

Dos Testigos: Yo, _____ soy un miembro del equipo medico y he sido testigo que el paciente ha firmado voluntariament este documento/rehusa firmar.

Firma del testigo _____
Titulo del testigo

Yo, _____ soy miembro del equipo medico que no es el proveedor del cuidado de salud del paciente para este procedimiento y he sido testigo que el paciente voluntariamente firmo este documento / rehuso firmar el documento.

Firma del testigo _____
Titulo del testigo

Yo me enterado que este paciente rehusa el proposito del tratramiento o intervencion/medicamento y a firmado este documento/rehusa firmar.

Firma del Medico _____
Fecha/Sello

*Si el paciente rehusa firmar este documento, pero verbalmente rechaza el procedimiento arriba descrito, escriba REHUSA FIRMAR ARRIBA Firma del Paciente.

Inmate Name _____
DC# _____ Race/Sex _____
Date of Birth _____
Institution _____