

REFUSAL OF TREATMENT OR SERVICES

I, _____, TDCJ-ID Number: _____ decline the following services and treatments at the Texas Department of Criminal Justice:

I understand the above documented treatment being refused is for the following condition(s):

I understand that potential outcome(s) for refusing the treatment for the above documented condition(s) includes but is not limited to the following:

I do not wish to have the above stated treatment or services. I assume full responsibility for any and all consequences or personal inconvenience that may arise from refusal of services.

I understand that I may still request these or similar services in the future.

Signature of Offender/TDCJ-ID #

Date

Signature of Witness (if offender unable or unwilling to sign)

Date

Reason offender did not sign: _____

I certify that the above named individual is present and appears to understand the above listed information.

Signature and Title of Health Care Personnel Obtaining Refusal

Date

I certify that the above named patient is alert and has demonstrated comprehension of the above explained condition, treatment, and potential consequences.