

REFUSAL OF TREATMENT OR SERVICES

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

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

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

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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.

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Signature of Inmate/TDCJ-ID #

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Date

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

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Date

Reason inmate did not sign: \_\_\_\_\_

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

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Signature and Title of Health Care Personnel Obtaining Refusal

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Date

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