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, the below-signed physician, 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 _____
- ☐ Examenes 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 recomemdada/ medicamento, tratamiento alterno, consequencias y peligros para mi salud y posible riesgos de muerte que puede resultar por no consentir a estos servicos de atencion medica.

Se me ha dado suficiente tiempo para hacer preguntas, consecuencias, los beneficios del tratamiento/ intervencion recomemdada, 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, el medico abajo firmante, 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_____

Incorporated by Reference in Rule 33-401.105, F.A.C.