PATIENT I.D. DATA:
(name, DOC #, birthdate)

REFUSAL OF MEDICAL, DENTAL, MENTAL HEALTH, AND/OR SURGICAL TREATMENT

DATE: ________________ TIME: ________________
(use 24-hour clock)

I, the undersigned, a patient at ____, hereby refuse the following medical, dental, mental health, and/or surgical treatment or procedure:

I refuse this treatment or procedure because:

This treatment or procedure has been recommended by the healthcare providers of this facility and they have carefully explained to me the following complications that may result:

I hereby release the facility, the Department of Corrections, the state of Washington, and their agents and employees/contract staff, including attending or responsible healthcare providers, from any and all liability related to any adverse effects or results caused by my refusal to accept the care and/or treatment which has been recommended or prescribed. I understand that I may change my mind regarding this refusal at any time; however, due to changes in my condition, this treatment may not be medically appropriate or necessary at that time.

PATIENT SIGNATURE	DATE

I have explained the risks and benefits and the patient is deemed competent to refuse this treatment.

NAME OF ORDERING PRACTITIONER / PROTOCOL PROVIDER	SIGNATURE OF ORDERING PRACTITIONER / PROTOCOL PROVIDER	DATE

☐ Interpreter used ☐ Telephonic interpretation used (enter business name below; signature not required)

NAME OF INTERPRETER	SIGNATURE OF INTERPRETER	DATE

NOTE: If patient refuses to sign form, witness to refusal, in addition to ordering practitioner/protocol provider, must sign.

Reason patient is refusing to sign form:

NAME OF WITNESS	SIGNATURE OF WITNESS	DATE

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.