DEPARTMENT OF CORRECTIONS
Medical Treatment Refusal Form

Offender Name/DOC ID#: _____

Date: _____

Time: _____

Facility/Program: _____

I, _____, DOC ID#_____

refuse to have treatment by _____.

I acknowledge that I have been informed of the risks and possible consequences of refusing medical treatment that may result in the following, including death:

_____
_____
_____
_____
_____
_____

I herby release the above named Licensed Provider and Montana Department of Corrections and their employees, agents, and contractors from all responsibility for any and all effects that may result from my refusal of treatment.

By signing this form, I acknowledge that I have signed at my own free will and without threat or coercion from staff.

_____ _____
Offender Signature Date & Time

_____ _____
Witness Date & Time

_____ _____
Witness Date & Time