Department of Health Services
Division of Primary Health
Adult Correctional Health

Consent for Medical Care

Patient's Name: _____ DOB: _____ X-Ref #: _____

I hereby authorize and give my consent for medical, psychiatric, and dental care to be administered to the above named patient while in the custody of the Sacramento County Sheriff's Department. This authorization for care is valid for the duration of current incarceration unless I provide written revocation.

Medical care shall include the administration of any treatment deemed necessary or advisable by the provider in charge of the care of the detained individual, including immunizations and the continuation of medications prescribed by any current treating provider(s) for medical, dental and/or psychiatric conditions unless deemed contraindicated upon examination by the provider in charge of the care of the detained individual. The undersigned consents to any x-ray examination, laboratory procedures, anesthesia, medical or surgical treatment, or medical clinic/hospital services rendered to the detained individual under the general and special instructions of the provider in charge.

I understand that in the case of a life-threatening condition, serious illness, or accident, reasonable effort will be made to obtain consent prior to the administration of medical care if time and conditions permit. However, if consent cannot be obtained, I hereby authorize staff to secure, without delay, such medical care as may be recommended by a licensed provider.

Any need for the provider in charge of the care of the detained individual or their designees to obtain or exchange information with another health care provider for the purpose of treatment will be done according to all federal, state and local laws governing protected health information.

Additional consent will be obtained prior to use of psychotropic medications and invasive procedures such as surgeries, invasive diagnostic tests, and dental extractions.

_____ _____
Signature of legally responsible person Date signed

_____ _____
Name of legally responsible person (please print) Telephone #

_____ _____
Street address, city, state and zip code Alternate Contact #

Obtained by: _____
Adult Correctional Health Staff