Sacramento County
Adult Correctional Health

Refusal

Name:	Date/Time:
X-Ref:	DOB:

I am refusing the following health care services offered at Sacramento County Jails:

☐ Medication(s): ______________________________

☐ This time only ☐ Permanently

☐ Medical appointment ☐ Dental appointment ☐ Psychiatric appointment
☐ Medical treatment ☐ Dental treatment ☐ Psychiatric treatment

Reason for refusal: ____

I hereby agree to release and hold harmless Sacramento County from all responsibility for ill effects that may result from my refusal. I personally assume responsibility for my own welfare should any ill effects occur as a result of my refusal.

____
Patient Signature

____
Witness Printed Name & Signature

____
2nd Witness Printed Name & Signature
If patient refuses to sign, two witnesses are required

Rev. 10/30/20

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