STATE OF ALASKA **DEPARTMENT OF CORRECTIONS**

Release of Medical/Dental/Vision and Financial Liability

When use of private health care provider is authorized

I, _____, Date of Birth _____ hereby inform the State of Alaska of my desire to have my private health care provider,

_____

provide treatment for _____.

I fully understand that this treatment can be provided by the state-selected provider at no cost to me. Notwithstanding, I have agreed to pay in advance for the service provided by the above-listed provider of my choosing.

I hereby release the State of Alaska and its agents of all liability for all Medical/Dental/ Vision conditions and/or treatments and complications of such. I hereby release the State of Alaska and its agents of liability for payment of services thus rendered and responsibility for any follow-up treatment directly related to these conditions.

_____ _____

Signature of Prisoner Date

_____ _____

Signature of Witness Date