

STATEMENT OF PATIENT RELEASING HOSPITAL/CLINIC FROM LIABILITY UPON LEAVING HOSPITAL/CLINIC AGAINST MEDICAL ADVICE

1. This is to certify that I am leaving \_\_\_\_\_ at my own insistence and against the advice of the hospital/clinic authorities and my attending physician(s).

(Name of Medical Treatment Facility)

2. I have been advised of and understand the potential dangers involved in leaving the hospital/clinic at this time. The potential medical risks that have been explained to me include:

3. I have been advised of and understand the follow-up actions recommended by my health care provider which include:

4. I hereby release the hospital/clinic, its staff and the Federal Government of all responsibility for any ill effects brought about by my failure to continue medical evaluation and/or treatment as recommended.

(Signature of Patient/Date and Time)

(Signature of Physician/Designee)

(Signature and Address of Witness)

STATEMENT OF REPRESENTATIVE OF PATIENT RELEASING HOSPITAL/CLINIC FROM LIABILITY UPON LEAVING HOSPITAL/CLINIC AGAINST MEDICAL ADVICE

1. Representative's name \_\_\_\_\_ Relationship to the patient \_\_\_\_\_

2. I, \_\_\_\_\_, insist that \_\_\_\_\_ be discharged/released from \_\_\_\_\_

(Representative's Name)

(Patient's Name)

(Name of Medical Treatment Facility)

3. I have been advised of and understand the potential dangers involved in having the patient leave the hospital/clinic at this time. The potential medical risks that have been explained to me include:

4. I have been advised of and understand the follow-up actions recommended for the patient which include:

5. I hereby release the hospital/clinic, its staff and the Federal Government of all responsibility for any ill effects associated with failure to continue \_\_\_\_\_'s medical evaluation and/or treatment as recommended.

(Patient's Name)

(Signature of Patient's Representative/Date and Time)

(Signature of Physician/Designee)

(Signature and Address of Witness)

Patient ID Plate or Printed Name and SSN, Address, and Daytime Telephone Number

PREPARED BY (Signature and Title)

DEPARTMENT/WARD/CLINIC

DATE (YYYYMMDD)

TIME