# DISCHARGE AGAINST MEDICAL ADVICE

This is to certify that I, …………………………………………………………………………………… ……………………………………… a patient at **“\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_”** am refusing at my own insistence and without the authority of and against the advice of my attending physician(s), request to give me discharge against medical advice.

The medical risks have been explained to me by a member of the medical staff and I understand those risks.

I hereby release the hospital, its administration, personnel, and my attending and/or resident physician(s) from any responsibilities for all consequences, which may result by my leaving under these circumstances.

Patient Signature/Thumb impression ……………………………………………….. Date ……………………………………..

Physician Signature ………………………………………………………………………….. Date ……………………………………..

Witness Signature ……………………………………………………………………………. Date …………………………………….