Montana Mental Health Nursing Care Center
Request for Discharge Against Medical Advice

This is to certify that I, _____, wish to discharge _____, from the Montana Mental Health Nursing Care Center. I understand that he/she will be discharged within (5) days of this request, to allow for any pre-discharge arrangements. I further understand that this discharge is against the advice of the attending physician and the facility administration. I hereby release the attending physician and the Montana Mental Health Nursing Care Center from all responsibility for any ill effects which may result from such discharge.

_____ _____
Resident or Responsible Party **Witness**

_____ _____
Resident or Responsible Party **Witness**

cc: Original to Medical Record
Social Service File
Resident or Guardian
Resident Accounts Office