MEDICAL RECORD	RELEASE AGAINST MEDICAL ADVICE For use of this form, see AR 40-68; proponent agency is the Office of The Surgeon General

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
(Name of Medical Treatment Facility)
hospital/clinic authorities and my attending physician(s).

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, _____ *(Representative's Name)*, insist that _____ *(Patient's Name)* be discharged/released from _____ *(Name of Medical Treatment Facility)* without the authorization of hospital/clinic authorities and his/her attending physician(s).

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 _____ *(Patient's Name)*'s medical evaluation and/or treatment as recommended.

_____ _____
(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