

DOCUMENTATION EXAMPLE



RELEASE OF RESPONSIBILITY FOR DISCHARGE AGAINST MEDICAL ADVICE

Form # MF5407 (09/07)

Reorder From: MED-PASS 800-438-8884

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INH07-404

This is to certify that I, _____ wish to discharge myself from this facility at my own insistence and against the advice or authority of my physician(s):

(Resident's Name)

(Physician's Name)

(Physician's Name)

(Physician's Name)

I have been informed of the dangers to my health and/or safety if I leave this facility.

I hereby release _____, its administration, staff and my physician(s) from all responsibility from any consequences that may result from my leaving the facility under these circumstances.

(Name of facility)

(Resident's Signature)

(Date)

This is to certify that _____ is discharging him/herself from _____, at their own insistence and against the advice of the facility staff and without the authority of their physician(s).

(Resident's Name)

(Name of Facility)

This resident has been informed of the dangers to his/her health and/or safety if he/she leaves. Further, this resident is refusing to sign the above release.

(Witness)

(Date)

(Time)

AM
 PM

(Witness)

(Date)

(Time)

AM
 PM

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Please call MED-PASS, Inc. at 800-438-8884 for an actual sample of the form or visit www.med-pass.com