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. _____ Date/Time: _____	Signature of Physician/Designee: _____ _____ Date/Time: _____

Witness Signature

_____ Date/Time: _____

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 PatientName _____ be discharged/released from
(Representative's Name) *(Patient's Name)*
_____ without the authorization of hospital/clinic authorities and his/her attending physician(s).
(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 PatientName 's medical evaluation and/or treatment as recommended.
(Patient's Name)

	Signature of Physician/Designee: _____ _____ Date/Time: _____

Witness Signature

_____ Date/Time: _____

Patient ID Plate or Printed Name and SSN, Address, and Daytime Telephone Number PatientName PatientMedicalRecordNumber|DM PatientDOB	PREPARED BY *(Signature and Title)* DEPARTMENT/WARD/CLINIC DATE *(YYYYMMDD)*	TIME