

Against Medical Advice - AMA

PATIENT AUTHORIZATION AND NOTICE

Patient Name

Date

Time of Visit

Hospital Location

REFUSAL OF RECOMMENDED TREATMENT

Medical examination, treatment, or testing has been recommended for me. I have decided to reject further treatment or medical evaluation, and will leave the facility.

I am refusing medical care of my own choice, and contrary to the instructions and wishes of the above provider or physician. I understand that permanent harm or even death can occur from failing to follow the recommendations of the provider/physician.

Because I am refusing recommended medical care, I agree to absolve and release the provider/physician and the practice from any and all liabilities for damages arising from any current medical condition. I accept all risk associated with my medical condition both known and unknown.

I assume all responsibility for this action. I agree that I will make no claim of any nature against this facility of the doctor under any circumstances.

LIST OF TREATMENT(S) REFUSED

Signature of patient or guardian

Date

Signature of Witness

Date