AGAINST MEDICAL ADVICE (AMA FORM)

This is to certify that I, _____,
a patient at _____(fill in name of your hospital), am refusing at my own insistence and without the authority of and against the advice of my attending physician(s) _____, request to leave against medical advice.

The medical risks/benefits have been explained to me by a member of the medical staff and I understand those risks.

I hereby release the medical center, its administration, personnel, and my attending and/or resident physician(s) from any responsibility for all consequences, which may result by my leaving under these circumstances.

MEDICAL RISKS

_____Death _____Additional pain and/or suffering

_____Risks to unborn fetus _____Permanent disability/disfigurement

_____Other:_____
_____
_____

MEDICAL BENEFITS

_____History/physical examination, further additional testing and treatment as indicated.
_____Radiological imaging such as:
_____CAT scan ____X-rays ____ ultrasound (sonogram)

_____Laboratory testing _____ Potentional admission and/or follow-up
_____Medications as indicated for infection, pain, blood pressure, etc.
_____Other:_____

Please return at any time for further testing or treatment

Patient Signature_____ Date_____

Physician Signature_____ Date_____

Witness _____ Date_____