

Departure Prior to Completion of Treatment

I, _____, hereby release this facility of all liabilities and responsibilities resulting from my voluntary departure before completion of treatment. I fully realize that this departure is against the medical advice of my physician and against the medical practices of this facility.

The benefits of treatment and the risks of refusing proposed medical treatment have been explained to me by a member of the medical staff. I understand these risks and accept full responsibility for the consequences of refusal of treatment.

I decline to discuss the benefits of treatment and the risks of refusal of treatment with a member of the medical staff

Resident or Power of Attorney declined to sign form prior to departure

_____ Date
Patient or Power of Attorney

_____ Date
Nursing Supervisor

At the time of my evaluation, _____ was able to express to me the nature of his/her illness, the available treatment options and the consequences of refusing treatment. I deemed him/her to have medical capacity to make decisions regarding his care.

_____ Printed Name and credentials
Signature of Medical Professional

The patient has been offered appropriate prescriptions and follow up appointment(s) to mitigate any harm caused by the patient's voluntary discharge prior to completion of treatment

_____ Printed Name and credentials
Signature of Medical Professional