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

_____ _____

Patient or Power of Attorney Date

_____ _____

Nursing Supervisor Date

☐ 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.

_____ _____

Signature of Medical Professional Printed Name and credentials

☐ 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

_____ _____

Signature of Medical Professional Printed Name and credentials