**SAMPLE Against Medical Advice (AMA) Discharge Form**

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Patient Name (please print) Patient DOB

The physician and/or designee on behalf of the physician have informed me of the following:

* The nature of my condition.
* The purpose of and need for continued hospital treatment.
* The purpose and nature of the proposed treatment, interventions, and/or procedures.
* The possible alternatives to continued hospital care.
* The probable consequences of not proceeding with hospital treatment or alternatives.

I acknowledge the following:

* The hospital staff has offered to examine me to determine my condition and to provide me with medical treatment, stabilizing treatment, and/or a medically appropriate transfer.
* I understand that if I refuse the services offered, I am doing so against medical advice, and that my refusal may result in a worsening of my condition—which could pose a threat to my life, health, and my medical safety.
* I have received discharge instructions.
* I understand I may return at any time and should return if my condition worsens.

 / / am/pm

Patient Signature (or signature of person completing form if not patient\*) Date Time

\*Relationship to patient: □ Parent □ Legal Guardian □ Other:

 / / am/pm

Witness Signature Date Time

 / / am/pm

Physician Signature Date Time

Patient left without signing (describe if known):