# Discharge Against Medical Advice (AMA) Form

**Patient Name:** ___________________________

**Patient ID/DOB:** ___________________________

**Date:** ___________________________

**Time:** ___________________________

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This is to certify that I, **[Patient Name or Legal Guardian]**, am requesting to be discharged from **[Facility Name]** against the advice of the attending physician and the medical staff.

**Acknowledgment of Risks:**

- The physician has explained the nature of my medical condition and the necessary treatments/diagnostic tests.
- I have been informed of the potential risks of leaving the hospital prematurely, which may include: **[List specific risks, e.g., permanent disability, worsening of infection, or death]**.
- I understand that by leaving against medical advice, I am assuming full responsibility for any injury or adverse outcomes that may result from this decision.
- I understand that I am welcome to return to this facility at any time if I seek further treatment.

**Physician Statement:**

I have explained to the patient (or legal representative) the risks involved in leaving the hospital at this time. The patient appears to have the mental capacity to understand these risks and has made an informed decision to leave.

**Signatures:**

Patient/Guardian Signature: ___________________________ Date: __________

Witness Signature: ___________________________ Date: __________

Physician Signature: ___________________________ Date: __________