URGENT CARE AGAINST MEDICAL ADVICE (AMA) DISCHARGE FORM

Date: [Date]

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Medical Record Number: [MRN/ID Number]

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1. PROVIDER ASSESSMENT:

I have examined the patient and determined that the following diagnostic tests or treatments are medically necessary at this time: [List tests/treatments, e.g., Chest X-ray, IV Antibiotics, Hospital Transfer].

2. RISKS OF LEAVING AGAINST MEDICAL ADVICE:

I have informed the patient (or their legal guardian) of the potential health risks of leaving this facility before completion of treatment or evaluation. These risks include, but are not limited to:

- Worsening of current condition
- Permanent disability or organ damage
- Delayed diagnosis of a life-threatening condition
- Severe infection or sepsis
- Death

3. PATIENT ACKNOWLEDGMENT:

I, [Patient/Guardian Name], acknowledge that I am choosing to leave [Clinic Name] against the express advice of the attending medical provider. I understand the risks stated above. I release the facility and the medical staff from any liability for complications or ill effects resulting from my decision to discontinue care.

4. FOLLOW-UP INSTRUCTIONS:

The patient has been instructed to seek immediate emergency care at the nearest hospital if symptoms worsen. The patient is advised to follow up with a primary care physician within [Number] hours.

SIGNATURES:

Patient/Guardian Signature: ____________________________ Date: __________ Time: ________

Witness Signature: ____________________________ Date: __________ Time: ________

Provider Signature: ____________________________ Date: __________ Time: ________

Refusal to Sign: [ ] Patient departed facility before signing; witnessed by: [Name/Staff Title]