**Date:** [Date]

**Patient Name:** [Patient Name]
**Patient ID/DOB:** [ID Number/Date of Birth]
**Provider Name:** [Physician Name]

---

Dear [Patient Name],

This letter serves as formal documentation that you have chosen to leave [Facility Name] on [Date] at [Time] against the strong medical advice of your attending physician and the clinical staff.

**Clinical Assessment:**
You were admitted for an evaluation and management of your chronic condition, specifically [Name of Chronic Illness]. At the time of your departure, your evaluation and treatment plan were incomplete.

**Risks of Premature Discharge:**
Your medical team has explained that leaving the hospital at this time poses significant risks to your health, including but not limited to:

- Worsening of chronic symptoms.
- Irreversible organ damage or disease progression.
- Development of acute complications or secondary infections.
- Inaccurate diagnosis due to incomplete testing.
- Permanent disability or death.

**Patient Acknowledgment:**
By departing against medical advice, you acknowledge that you have been informed of these risks and have decided to assume full responsibility for the consequences of your departure. You have also been informed that your insurance provider may refuse coverage for this admission due to your decision to leave against medical advice.

**Follow-Up Instructions:**
Despite your decision to leave, we recommend the following immediate actions:

- Contact your primary care physician, [PCP Name], at [PCP Phone Number] within 24 hours.
- Seek immediate emergency care at the nearest hospital if you experience [Specific Warning Symptoms].
- Continue taking currently prescribed medications unless otherwise directed by a physician.

If you change your mind, you are welcome to return to our emergency department at any time for reassessment.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Facility Name]

**Witness:**
[Witness Name/Signature]