

Date: [Date]

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Medical Record Number: [MRN]

To: [Doctor/Physician Name]

RE: Refusal of Prescribed Medication Against Medical Advice (AMA)

I, [Patient Name], am writing to formally document my decision to refuse the following medication(s) prescribed to me on [Date]:

Medication Name: [Name of Medication]

My physician has explained to me the medical reasons for this prescription and the potential benefits of taking this medication. I also acknowledge that my physician has explained the potential risks and clinical consequences of refusing this treatment, which may include:

- Worsening of my current medical condition.
- Permanent disability or long-term health complications.
- Potential life-threatening symptoms or death.

Despite being informed of these risks, I have decided to refuse this medication for the following reasons: [Optional: Insert Reason].

I confirm that I am making this decision voluntarily and that I have had the opportunity to ask questions regarding this treatment plan. I understand that I am acting against the formal medical advice of my healthcare provider. I release [Physician Name] and [Clinic/Hospital Name] from any liability for damages or complications that may result from my refusal of this medication.

Sincerely,

Patient/Legal Guardian Signature

Witness Signature (if applicable)