Date: [Date]

Patient Name: [Patient Name]

Date of Birth: [DOB]

Medical Record Number: [MRN]

Dear [Patient Name],

This letter confirms that you have chosen to discharge yourself from [Hospital/Facility Name] on [Date] at [Time] against the formal medical advice of your attending physician, [Physician Name].

Medical Risks
Your medical team has advised you that leaving the hospital at this time carries significant risks to your health and, if applicable, the health of your unborn child. These risks include, but are not limited to:

- [Insert Specific Risk, e.g., Uncontrolled Hemorrhage]
- [Insert Specific Risk, e.g., Preeclampsia complications/Seizures]
- [Insert Specific Risk, e.g., Fetal distress or preterm labor]
- Infection, permanent injury, or death.

Discharge Instructions
Despite your decision to leave, we recommend the following immediate steps:

- Follow up with your OB/GYN within [Number] hours/days.
- Continue taking the following medications: [List Medications].
- Seek emergency care immediately if you experience: heavy bleeding, severe headache, vision changes, or decreased fetal movement.

Patient Acknowledgment
By leaving, you acknowledge that you have been informed of the potential dangers of departing before your treatment is complete. You understand that the hospital and medical staff are not responsible for any adverse outcomes resulting from this decision.

If you change your mind, you are welcome to return to the Emergency Department at any time for evaluation and care.

Sincerely,

[Physician Signature]
[Physician Name/Title]

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____