

URGENT CARE FACILITY NAME: [Insert Name]

DATE: [Insert Date]

PATIENT NAME: [Insert Name]

DATE OF BIRTH: [Insert DOB]

REFUSAL OF TREATMENT / DISCHARGE AGAINST MEDICAL ADVICE (AMA)

I, [Patient Name or Legal Guardian], acknowledge that I am choosing to leave [Urgent Care Name] against the expressed advice of the attending medical provider, [Provider Name].

Medical Provider's Assessment:

The provider has informed me of the following suspected or confirmed diagnosis: [Insert Diagnosis/Condition].

Risks of Leaving Against Medical Advice:

I have been clearly informed that by leaving the facility at this time, I am risking serious health consequences, which may include but are not limited to:

- Worsening of the current condition
- Permanent physical or mental disability
- Infection or sepsis
- Organ failure
- Death

Patient Acknowledgement:

I understand that the medical evaluation and treatment are not complete. I acknowledge that I have had the opportunity to ask questions and that the provider has explained the risks of refusing further care. I assume full responsibility for any injury or harmful outcomes that may result from my decision to leave.

Follow-Up Instructions:

I have been advised to seek immediate medical attention at the nearest Emergency Room if symptoms worsen. I am also advised to follow up with a primary care physician within [Number] hours/days.

Patient/Guardian Signature

Witness Signature

Medical Provider Signature