[Hospital or Clinic Name]
[Department]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

RE: NOTICE OF DISCHARGE AGAINST MEDICAL ADVICE

Dear [Patient Name],

This letter is to formally document that you have decided to leave [Facility Name] and refuse the recommended medical treatment for [Condition/Diagnosis] as of [Date] at [Time].

As discussed with [Physician Name], the recommended course of treatment included: [List treatments refused].

During our consultation, you were informed of the potential risks and complications associated with refusing this treatment, which may include, but are not limited to:

- Worsening of your current condition
- Permanent disability or impairment
- Chronic pain
- [Specific Medical Risk]
- Death

By signing the "Against Medical Advice" (AMA) form or choosing to leave the facility, you acknowledge that you understand these risks and are choosing to decline further care at this time. Consequently, we are officially discharging you from our immediate care.

Please be advised that if you change your mind or if your symptoms worsen, you should seek emergency medical attention immediately at the nearest emergency room or call 911.

We recommend that you follow up with your primary care provider, [Primary Care Physician Name], within [Number] days to discuss your ongoing health needs.

Sincerely,

[Physician Signature]
[Physician Name, Title]
[Facility Name]