Rejection of Recommended Treatment
(Against Medical Advice)

Medical examination, treatment, or testing has been recommended for me. I have decided to reject further treatment or medical evaluation, and will leave the facility.

I am rejecting medical care of my own choice, and contrary to the instructions and wishes of _____ the treating physician. I understand that permanent harm, or even death, can occur from failing to follow the recommendations of the physician. I have had an opportunity to ask questions and fully understand my medical condition. I have been advised that I may return at any time to continue medical evaluation or treatment.

Because I am rejecting recommended medical care, I agree to absolve and release the physician and the medical facility from any and all liabilities for damages arising from any current medical condition. I accept all risk associated with my medical condition, both known and unknown. I assume all responsibility for this action. I agree that I will make no claim of any nature against this medical facility or the physician under any circumstances.

_____
Name of Patient

_____
Signature of Patient or Guardian of Same

_____
Date

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