MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*		ISSUANCE DATE
REFUSING CARE OR TREATMENT	NAVHOSPPNCLAINST 6320.65C	08 Sep 2016
LOCAL FORM TITLE *(Optional)*		
HOSPITAL RELEASE		

To: Commanding Officer, Naval Hospital, Pensacola, FL

From: _____ _____

Patient's Name (LAST) (FIRST) Ward

This is to certify that I am, this date, leaving the Naval Hospital, Pensacola, Florida against medical advice (AMA) and/or refusing advised treatment and have been apprised of the risk by Naval Hospital. As a result of this action, I hereby release Naval Hospital Pensacola and its staff of medical officers of responsibility that may arise as a result of this action.

I have been advised of the risks associated with leaving AMA or refusing the advised treatment/procedure. These risks include, but are not limited to the following:

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_____ _____

SIGNED (PATIENT/PARENT, IF MINOR CHILD) DATE / TIME

_____ _____

PRINTED NAME / SIGNATURE (OFFICER OF THE DAY (OOD)) DATE / TIME

ORIGINAL TO: Patient's Medical Record
COPY TO: OOD and Risk Management (RM)
NOTE: Submit a Patient Safety Report via PSR and forward to RM.

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	