

**DISCHARGE AGAINST MEDICAL ADVICE**

**Date:** \_\_\_\_\_

**Time:** \_\_\_\_\_

This is to certify that I, \_\_\_\_\_, a patient in Naval Hospital, Oak Harbor, Washington, am leaving the hospital against the advice of \_\_\_\_\_, my attending physician, and the hospital authorities.

I acknowledge that I have been informed of the risks involved; which include, among others:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby release the attending physician, Naval Hospital, Oak Harbor, and the United States Government from all responsibility and liability for ill effects which may result from this action, and I assume full responsibility therefor.

\_\_\_\_\_  
**PATIENT**

or

\_\_\_\_\_  
**AUTHORIZED REPRESENTATIVE/RELATIONSHIP**

\_\_\_\_\_  
**WITNESS**

\_\_\_\_\_  
**WITNESS**

**Reason for not granting discharge at this time:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**PHYSICIAN**

(If patient or his representative refuses to sign, form should be completed, witnessed by personnel present at time of refusal, and the statement "SIGNATURE REFUSED" noted on the form.)