FORM 5-3

Leaving Hospital Against Medical Advice

Name of Hospital: _____

Patient's Name: _____

I am voluntarily leaving the hospital against the advice of *(physician name)* _____ _____ and a representative of the hospital administration.

I have been told by the doctor about the risks and consequences involved in leaving the hospital at this time, the benefits of continued treatment and hospitalization, and the alternatives, if any, to continued treatment and hospitalization.

I hereby release the doctor, any other doctors involved in my care, the hospital and its employees and agents from all responsibility for any injury or ill effects which may result from this action.

I understand that the doctor named above and other doctors who provide services to me are not employees or agents of the hospital. They are independent medical practitioners.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

Signature: _____
(witness)

Print name: _____
(witness)

I declare that I have personally explained to the patient the risks and consequences involved in leaving the hospital at this time, the benefits of continued treatment and hospitalization, and the alternatives, if any, to continued treatment and hospitalization.

Remarks: _____

_____

Date: _____ Time: _____ AM / PM

Signature: _____
(physician)

Print name: _____
(physician)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

FORM 5-3S

Salida del Hospital en Contra del Consejo Medico

Nombre del Hospital: _____

Nombre del Paciente: _____

Voluntariamente salgo del hospital en contra del consejo del *(nombre de médico)* _____ _____ y un representante de la administración del hospital.

El doctor me ha informado de los riesgos y consecuencias relacionados con salir del hospital en este momento, de los beneficios del tratamiento y hospitalización continuados, y las alternativas, en su caso, al tratamiento y la hospitalización continuados.

Por medio de la presente exonero al médico, a cualesquiera otros médicos involucrados en mi atención médica, al hospital y a sus empleados y representantes de toda responsabilidad por cualquier lesión o efecto adverso que pueda resultar de esta acción.

Entiendo que el médico cuyo nombre se indica anteriormente y otros médicos que me brindan servicios no son empleados ni agentes del hospital. Son médicos facultativos independientes.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

Firma: _____
(testigo)

Nombre en letra de imprenta: _____
(testigo)

I declare that I have personally explained to the patient the risks and consequences involved in leaving the hospital at this time, the benefits of continued treatment and hospitalization, and the alternatives, if any, to continued treatment and hospitalization.

Remarks: _____

_____

Date: _____ Time: _____ AM / PM

Signature: _____
(physician)

Print name: _____
(physician)

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*