FORM 9-10

Temporary Absence Release

Patient Name: ____

The attending physician has granted permission for me/the patient to be absent from the hospital for my/the patient's convenience from *(time)* ______________, *(date)* __________________to *(time)*____________________________, *(date)* ______________________________.

I assume all responsibility for myself/the patient during the temporary absence and hereby release *(hospital name)* ____, its employees, and the attending physician(s) from all responsibility during this absence and for my/the patient's condition as a result thereof.

Private medical insurance programs and publicly funded programs, such as Medi-Cal and Medicare, may or may not provide hospitalization benefits for the period of time during and subsequent to the time I/the patient is away from the hospital. If the private or public insurance program does not provide such hospitalization benefits, I/the person responsible for the patient's hospitalization expenses will, to the extent permitted by law, remain obligated to pay the hospital for such expenses in accordance with the hospital's regular rates and terms.

I understand that the physicians involved in my care 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)

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

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FORM 9-10S

Exoneracion De Responsabilidad Urante Una Ausencia Temporal

Nombre del Paciente: ______________________________

El médico del caso ha dado su permiso para que yo/el paciente esté ausente del hospital por conveniencia mía/del paciente desde las *(hora)* ______________, *(fecha)* ______________ hasta las *(hora)* ______________, *(fecha)* ______________.

Asumo toda responsabilidad por mí mismo/el paciente durante la ausencia temporal y por medio de la presente exonero a *(nombre del hospital)* ______________________________, a sus empleados y a los médicos del caso de toda responsabilidad durante esta ausencia y por la condición mía/del paciente como resultado de dicha ausencia.

Los programas de seguros médicos particulares y los programas financiados públicamente, tales como Medi-Cal y Medicare, pueden o no proveer beneficios de hospitalización para el período de tiempo durante y subsecuente en que yo/el paciente esté fuera del hospital. En caso de que el programa de seguros particular y/o público no proporcionara dichos beneficios de hospitalización, yo/la persona con la responsabilidad financiera por los gastos de hospitalización del paciente quedará obligada, hasta el límite permitido por la ley, a pagar al hospital dichos gastos de acuerdo con las tarifas y condiciones normales del hospital.

Entiendo que el médico que me atiende 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)

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