I (PATIENT'S NAME) _____

CERTIFY THAT I AM LEAVING LEE MEMORIAL HEALTH SYSTEM AT MY OWN INSISTENCE AND AGAINST THE ADVICE OF THE HOSPITAL AUTHORITIES AND MY PHYSICIAN(S). I HAVE BEEN INFORMED BY THEM OF THE DANGERS ATTENDANT ON MY LEAVING THE HOSPITAL AT THIS TIME. I ASSUME ALL RESPONSIBILITY FOR ANY RESULTS CAUSED BY LEAVING THE HOSPITAL PREMATURELY, AND I HEREBY RELEASE AND HOLD HARMLESS THE HOSPITAL, ITS EMPLOYEES AND OFFICERS, AND MY PHYSICIAN(S) FROM ANY AND ALL LIABILITY ARISING OUT OF THIS DECISION AND MY DEPARTURE.

DATE/TIME: _____ PATIENT SIGNATURE: _____

WITNESS SIGNATURE: _____

I HEREBY AGREE TO HOLD HARMLESS LEE MEMORIAL HEALTH SYSTEM, ITS EMPLOYEES AND OFFICERS AND PHYSICIAN(S) FOR THE ABOVE NAMED PATIENT FROM ANY AND ALL LIABILITY ARISING OUT OF THE DISCHARGE OF THE ABOVE NAMED PATIENT.

DATE/TIME: _____ HUSBAND, WIFE, PARENT
OR LEGAL GUARDIAN: _____

WITNESS SIGNATURE: _____

REASON(S) FOR LEAVING: _____

_____

_____

_____

IF THE PATIENT REFUSES TO SIGN SUCH A STATEMENT, THIS FORM SHOULD BE COMPLETED, WITNESSED BY THE HOSPITAL PERSONNEL PRESENT AND THE STATEMENT MADE ON THE FORM "SIGNATURE REFUSED".

FOLLOW LEE MEMORIAL HEALTH SYSTEM ADMINISTRATIVE POLICY & PROCEDURE M03 07 706 & S08 05 876.

LEE MEMORIAL HEALTH SYSTEM
Lee County, Florida

STATEMENT OF PATIENT LEAVING AGAINST MEDICAL ADVICE

FM# 0007 11/09

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