DEPARTURE AGAINST MEDICAL ADVICE

1. This certifies that I am leaving (taking the named patient from) The Brooklyn Hospital against the advice of my/the patient's physician and Hospital authorities.

2. Dr. ___________________________ has informed me of the dangers to my/the patient's physical and mental health which accompany discharge from the Hospital at this time. I have been given the opportunity to ask any questions and all my questions have been answered fully and satisfactorily.

3. I personally assume the risk and consequences of this discharge and release the Hospital, its governing body, officers, appointees, agents, employees, students and medical staff from any and all liability and consequences which may result from this discharge.

4. I confirm that I have read and fully understand the above and that all the blank spaces have been completed prior to my signing.

Patient/Relative or Guardian*: ___________________________ (SIGNATURE) ___________________________ (DATE) ___________________________ (PRINT NAME)

Relationship, if signed by person other than patient _____________________________________________________________

If Required Interpreter ___________________________ (SIGNATURE) ___________________________ (PRINT NAME)

Witness ___________________________ (SIGNATURE) ___________________________ (PRINT NAME)

*The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incompetent to sign.

I hereby certify that I have explained the dangers which accompany discharge at this time, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Physician: ___________________________ (Signature) ___________________________ (Date)