

Discharge AMA or RAS



Patient Information

| | | | |
|-------|---------|------|------------------|
| Name: | Record# | DOB: | Date of Service: |
|-------|---------|------|------------------|

Criteria for Refusing Care

The patient meets all of the following:

1. Is an adult (18 and over), or if <18, meets the criteria stated in the AMA/RAS Policy
2. Exhibits no evidence of:
 - Altered level of consciousness.
 - Alcohol or drug ingestion that impairs judgment.
3. Understands the nature of the medical condition. as well as the risks and consequences of refusing care.

Acknowledgement of Information

Against Medical Advice: I have been advised that medical assistance on my behalf is necessary, and that refusal of said assistance could be hazardous to my health, and under certain circumstances, including disability and/or death. I have been advised to discuss my medical complaints with my regular health care provider as soon as possible. Nevertheless, I refuse to accept treatment or transport to a medical facility and assume all risks and consequences of any decision.

OR **EMS Transport Refusal:** I acknowledge that I may have a medical problem, which may require additional medical attention, and that an ambulance is available to transport me to the hospital. Instead, I elect to seek alternative medical care and refuse further treatment and/or transport.

Release of Liability

By signing this form, I am releasing LoginClinics, PLLC of any liability or medical claims resulting from my decision to refuse the medical care/transport offered. I have read the "Acknowledgement of Information" and "Release of Liability." I also acknowledge that I have received a Notice of Privacy Practices.

Signature Relationship (if not patient): Lawful parent guardian conservator (pertains to a child/dependent only) Refuse to Sign reason: _____

| | |
|------------------------------------|------------------|
| Physician Consulted: | Witnessed By: |
| Telephone Consent/Refusal Obtained | Interpreter Used |

Disposition

Released in care or custody of self.
 Released in custody of law enforcement.
Agency: _____
Badge #: _____
Released in care or custody of:
 Parent Guardian Other _____

Instructions

1. If you change your mind, or your condition changes, call 9-1-1 (in case of emergency), go to an emergency department in your area, or call your private doctor (if appropriate).

2. _____
3. _____

| | |
|---------------|------------|
| Completed by: | Signature: |
|---------------|------------|

Witness Information

| | |
|--------------------------|---------------|
| Name (printed): | Signature: |
| Relationship to patient: | Phone Number: |