Oljabet Hospital

Telephone; 0703 333 111

Email: oljabethospital@yahoo.com

OLJABET HOSPITAL DISCHARGE AGAINST MEDICAL ADVICE FORM

Patient Information:

Patient Name: _____

Medical Record Number: _____ Date of Birth: _____

Date of Admission: _____Date of Discharge: _____

I, _____, hereby request to be discharged against medical advice from Oljabet Hospital. I understand that leaving the hospital against medical advice may result in serious complications, including the need for further medical treatment and hospitalization.

I acknowledge that the hospital staff has advised me against leaving and has explained the potential consequences of my decision. I understand that the hospital cannot be held responsible for any adverse outcomes resulting from my decision to leave.

I hereby release Oljabet Hospital, its employees, physicians, and agents from any and all claims, liabilities, or damages arising from my decision to leave the hospital against medical advice.

I understand that I may be asked to sign additional forms and waivers related to my discharge against medical advice.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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Patient Information:

Patient Name: _____

Date of Birth: _____ Medical Record Number: _____

Date of Admission: _____ Date of Discharge: _____

I, _____, hereby request to be discharged against medical advice from Oljabet Hospital. I understand that leaving the hospital against medical advice may result in serious complications and potentially worsen my medical condition.

I acknowledge that the hospital staff has advised me against leaving and has explained the potential consequences of my decision. I have had the opportunity to ask questions and have had my concerns addressed to my satisfaction.

I understand that by leaving the hospital against medical advice, I am assuming all responsibility for any negative outcomes that may result from my decision. I agree to release Oljabet Hospital, its employees, physicians, and agents from any and all claims, liabilities, or damages arising from my decision to leave the hospital against medical advice.

I understand that I may be asked to sign additional forms and waivers related to my discharge against medical advice.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Physician Signature: _____ Date: _____