HARBOR - UCLA MEDICAL CENTER

RELEASE FROM MEDICAL RESPONSIBILITIES

I fully understand that only emergency treatment has been rendered to me and that I am to consult my private physician *immediately* for further medical care. I relieve Los Angeles County of any further responsibility.

Signature of Patient or Other Responsible Person	Relationship	Date

REFUSAL OF MEDICAL CARE

I refuse such medical care as recommended by the Physicians of the Los Angeles County Harbor-UCLA Medical Center and relieve them of any further responsibility.

Signature of Patient or Other Responsible Person	Relationship	Date

LEAVING THE HOSPITAL AGAINST MEDICAL ADVICE

This is to certify that I, _____, a patient in the above named Hospital, am leaving the Hospital against the advice of the attending physician and Hospital Administration. I acknowledge that I have been informed of the risk involved and hereby release the attending physician, the Hospital and the County of Los Angeles from all responsibility and all ill effect which may result from this action.

I am fully aware that I have been given a normal discharge amount of medication and that I have been instructed by proper medical personnel regarding dosage.

I have also been advised to return to this hospital in case of a reaction, to receive whatever treatment necessary.

Signature of Patient or Other Responsible Person	Relationship	Date

Address	City	State	Zip Code

Witness	Title	Date

Witness	Title	Date