



NU2C104

RELEASE FROM LIABILITY FOR DISCHARGE

Date: _____	Time: _____	AM PM
Patient: _____ (Last name) (First name) (Middle initial)		Age at last birthday (Patients under 18 must complete Supplemental section, printed on side 2)
_____ (Home address)		Telephone number: _____

- This is to certify that I
 - (am leaving the hospital)
 - (am taking my _____ from the hospital) against the advice of both attending physicians and the hospital administration.
- I have been informed by them of the dangers to (my) (my child's) health which accompany discharge from the hospital at this time. These dangers include: _____
- I personally assume the risks and consequences at this time, and release all physicians who have been consulted in (my) (my child's) case and the hospital and its staff from any liability for any ill effects which may result from discharge at this time.
- I acknowledge that I have read this document in its entirety, that I fully understand it, and that all blank spaces have been either completed or crossed-off prior to my signing.

Date: _____ Signature: _____

If consenting party is other than the patient:

Signature of Father Signature of Other (state relationship)

Signature of Mother Signature of Other (state relationship)

Witnesses: _____
Signature Address

Signature Address

NOTE: A hospital administrator should be consulted before reliance on the consent of any person other than the patient on behalf of a patient over the age of eighteen years of age.