Mount Sinai

The Mount Sinai Hospital
One Gustave L. Levy Place
New York, New York 10029

MRN -
V -

Date
Name
Unit #
Sex/DOB
Physician Service

UNAUTHORIZED DEPARTURE

1. This certifies that I am leaving/taking the above-named patient from the Mount Sinai Medical Center against the advice of my/the patient's physician and Hospital authorities.

2. I have been informed in a language I understand of the dangers to me/the patient's physical and or mental health which accompany discharge from the Medical Center at this time. I have been given the opportunity to ask 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 Medical Center, its employees, students and medical staff from any liability which may result from the discharge.

Patient, Relative, or Guardian* _____ (Print Name) _____ (Signature) _____ (Date / Time) (_____) (Relationship)

Signature Witness _____ (Print Name / Title) _____ (Signature) _____ (Date / Time)

This certifies I informed the patient of the risks of unauthorized departure. The patient/representative refused to sign the above.

_____ (Staff Member Signature) _____ (Date)

C2F12 (Rev. 9/08)