

Montana Mental Health Nursing Care Center Request for Discharge Against Medical Advice

This is to certify that I, _____, wish to discharge _____, from the Montana Mental Health Nursing Care Center. I understand that he/she will be discharged within (5) days of this request, to allow for any pre-discharge arrangements. I further understand that this discharge is against the advice of the attending physician and the facility administration. I hereby release the attending physician and the Montana Mental Health Nursing Care Center from all responsibility for any ill effects which may result from such discharge.

Resident or Responsible Party

Witness

Resident or Responsible Party

Witness

- cc: Original to Medical Record
- Social Service File
- Resident or Guardian
- Resident Accounts Office