Place Patient Form Label Here

BCW RELEASE FROM RESPONSIBILITY FOR DISCHARGE

Consent Discharge

Date: _____

Time: _____

THIS IS TO CERTIFY THAT I am removing _____
(Name of Patient)

from BC Women's Hospital + Health Centre, a program of the Provincial Health Services Authority. I acknowledge that I have been informed of the risk(s) involved and hereby release the staff, physicians, my attending physician, and the BC Women's Hospital + Health Centre from any and all responsibility for any ill effects which may result from such discharge.

Signed: _____
(Parent or Person Legally Authorized to Give Consent)

Relationship to Client/Patient: _____

Witness: _____
(The client has signed this while I was with the patient/client and stated that the patient/client understood what was stated.)

This authorization is valid until the termination of treatment or cancellation by client/patient, or for one year from the date of signing, whichever comes first.