Kaleida Health has an obligation to provide medical screening exam and stabilizing treatment to all patients who present to their Emergency Department regardless of their ability to pay or insurance status.

**ABSCOND**

☐ The patient was found to have absconded at: ___ ☐ AM  ___ ☐ PM on: ______________

Signed: ___________________________________________ Date

Title

**LEAVING WITHOUT BEING SEEN BY A PHYSICIAN**

☐ This is to certify that I, the undersigned, am declining to wait for Medical Screening Exam and am leaving without being seen. I acknowledge that I am aware of the risks of death or disability and hereby release the attending physician and Kaleida Health from any responsibility for any ill effects which may result from my actions. I understand that I have not been evaluated by a physician and specific risks to my health cannot yet be identified.

**LEAVING AGAINST MEDICAL ADVICE - ADULT PATIENT**

☐ I acknowledge that I, the undersigned, am leaving against the advice of the attending physician and Kaleida Health. I acknowledge that I have been informed of the risks involved and hereby release the attending physician and Kaleida Health from any and all responsibility for any ill effects which may result from such discharge.

☐ The risk of leaving against medical advice include death, disability or progression of your illness. Specific additional risks may include:

☐ The benefits of not leaving include correct diagnosis, therapy and reduced risk of further illness or death. Additional benefits may include:

I understand that I am always welcome to return for further evaluation in the Emergency Department.

Signed: ___________________________________________ _______________ 

Patient or Authorized Person  Date  Time  ☐ AM  ☐ PM

Relationship to Patient: ________________________________

Signed: ___________________________________________ _______________ 

Witness  Date  Time  ☐ AM  ☐ PM

☐ Patient refused to sign form