RELEASE OF RESPONSIBILITY FOR LEAVE OF ABSENCE

Date:_____ Time:_____ ❍ AM ❍ PM

I, _____, hereby accept complete responsibility for

_____ while away from _____
NAME OF PATIENT/RESIDENT NAME OF FACILITY

and absolve the management of this facility, its personnel and the attending physician of responsibility for any deterioration in condition, or accident that may happen while the patient/resident is away.

I understand that a bed will be reserved for the above-named patient/resident when he/she returns on or before_____ ❍ AM ❍ PM _____
RETURN DATE

_____ _____
PATIENT/RESIDENT/REPRESENTATIVE RELATIONSHIP TO PATIENT/RESIDENT

_____ _____
FACILITY REPRESENTATIVE TITLE

Authorization must be signed by the patient/resident, or by the nearest relative in the case of a minor or when patient/resident is physically or mentally incompetent.