RELEASE OF RESPONSIBILITY FOR LEAVE OF ABSENCE

I, the undersigned, hereby accept complete responsibility for___

(NAME OF FACILITY)

(NAME OF RESIDENT/PATIENT)

while away from ____

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 resident/patient is away from this facility.

I understand that a bed will be reserved for this resident/patient when they return on or before the designated date and time.

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

SIGN OUT			SIGN IN			
Date	Time	Signature of Person Accepting Responsibility	Address/Phone of Destination	Date	Time	Signature of Facility Representative
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