## **RELEASE OF RESPONSIBILITY FOR LEAVE OF ABSENCE**

I, the undersigned, hereby accept complete responsibility for					(NAME OF RESIDENT/PATIENT)		
(NAME OF FACILITY)					and absolve the management of this facility,		
		I the attending physician t/patient is away from th	of responsibility for any deternis facility.	ioration in conditi	on or acc	cident that may happen	
I under time.	stand that	a bed will be reserved	for this resident/patient when	they return on or	before th	ne designated date and	
	Authorizatio	on must be signed by the resident/pa	tient or by the nearest relative in the case of a r	minor or when person is ph	ysically or me	entally 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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