MR#___________ Patient Name:______________________________ DOB:____________

KAMRAN GOUDARZI, MD
Phone: (910) 726-3737
Fax: (910) 726-3712

AGAINST MEDICAL ADVICE
(AMA FORM)

This is to certify that **I**, ____, a patient of Kamran Goudarzi, MD, **am requesting, at my own insistence and without the authority of and against the medical advice of my attending physician(s)**, ____, MD, **to:**

- ☐ Walk to my car without the use of a wheelchair
- ☐ Leave the office after treatment without an adult driver to transport me home
- ☐ Leave the office against medical advice
- ☐ Other:____
  ____

The medical risks and benefits have been explained to me by a member of the medical staff and I understand those risks.

Medical Risks

- Additional pain and/or suffering
- Fall, resulting in injury
- Permanent disability/disfigurement
- Death
- Other:____
  ____

I hereby release Kamran Goudarzi, MD and its administration and personnel, and my attending physician(s) from any responsibility for all consequences which may result by my leaving under these circumstances.

Patient Signature____ Date_____________________

Physician Signature______________________________________ Date_____________________

Witness____ Date_____________________