PATIENT DISCHARGE FORM

Patient Name: ______________________ Patient ID: ______________

Attending Physician: ______________________ Physician License No.: ______

Admission Details:

Admission Date and Time: ______________________

Reason for Admission: ______________________

Discharge Details:

Discharge Date and Time: ______________________

Discharge Condition: ______________________

Follow-up Instructions: ______________________

Medications at Discharge:

Patient is discharged with the following medications and instructions to take as prescribed. The patient acknowledges understanding the medication regimen and possible side effects. Any changes from prior medications have been explained.

Patient Instructions and Warnings:

Patient is instructed to follow all discharge recommendations carefully. This includes rest, diet, activity restrictions, wound care, and signs or symptoms to watch for. Any unexpected or severe symptoms should prompt immediate medical attention or contact with the provider. By signing below, patient acknowledges receipt of discharge instructions and understanding of care plan.

Legal Disclaimers and Acknowledgements:

The undersigned patient and/or legal guardian acknowledges that all medical care and instructions received are understood and accepted. Any questions have been answered to the satisfaction of the patient. The healthcare provider is released from liability upon discharge, except for any future care explicitly agreed upon in writing. The patient agrees to comply with all post-discharge care requirements and follow-up appointments. This document is legally binding and enforceable under United States law.

Signatures and Certifications:

Patient or Legal Guardian Name: ______________________

Signature: ______________________ Date: ______________

Attending Physician Name: ______________________

Signature: ______________________ Date: ______________

Witness Name: ______________________

Signature: ______________________ Date: ______________

PATIENT / LEGAL GUARDIAN SIGNATURE	**ATTENDING PHYSICIAN SIGNATURE**
Signature: ___________________________	Signature: ___________________________

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