PERMISSION FOR TRANSFER

This is to certify that I _____

have been examined at **COUNTY HOSPITAL**

and that I have:

Stable Patient (check)

☐ 1. Given my consent to a transfer from this hospital to another facility. I acknowledge that I have been fully informed of the risks and benefits involved in the transfer. I hereby release the attending physician and the hospital from all responsibility for any change or worsening in my condition that may result from the transfer.

Unstable Patient (check one)

☐ 1. Requested a transfer from this hospital to another facility. I acknowledge that I have been fully informed of the risks and benefits involved in the transfer and I have requested the transfer. I hereby release the attending physician and the hospital from all responsibility for any change or worsening in my condition that may result from the transfer.

☐ 2. Have not requested a transfer from this facility. I acknowledge that I have been fully informed of the risks and benefits involved in a transfer from this facility. I hereby release the attending physician and the hospital from all responsibility for any change or worsening in my condition that may result from my failure to request a transfer.

All Patients (check)

☐ 1. Consented to treatment or examination.

All Patients

☐ 1. The risks and benefits of transfer are (include risks and benefits to unborn child in the case of pregnant women):

_____

_____

_____

_____

All Patients

☐ 1. I acknowledge that I have been told of the hospital's obligation under federal law to provide screening and emergency medical treatment.

_____ _____ **Date**_____

Witness ***Patient's Signature***

_____ _____ **Date**_____

Witness ***Signature of Legally Responsible Person for Patient***