

PATIENT: 900000 TEST SINGLE PATIENT DO NOT CREATE ANOTHER	SERVICE: 0013720742	DATE: 04/12/2024
BIRTH: 01/22/1980 AGE:	GENDER: Male UNIT:	HOSPITAL PERIOD:
INSURANCE: PRIVATE(CBHPM)(PAID)	PLAN: STANDARD PLAN	

I hereby request my discharge on request of Hospital São Rafael, considering that I do not wish, of my own free will, to remain hospitalized/under observation, even after having been extensively warned by the Hospital's medical team about the risks involved in my decision and the need to remain in hospital and continue the proposed treatment.

I have been informed that, although it is not possible to fully predict all possible or probable harm to my health, resulting from my discharge on request, my request to be discharged may pose, among others, the following risks:

- 1)
- 2)
- 3)
- 4)

Therefore, I request, **against express medical advice**, my DISCHARGE ON REQUEST, having been informed that such procedure matters in **refusal to treatment** recommended by the physician, therefore I exempt Hospital São Rafael and its professionals from any responsibility for any damages I may suffer as a result of my discharge.

That said, I sign this request, in the presence of two (2) witnesses

SIGNATURE OF THE PATIENT OR LEGALLY RESPONSIBLE PERSON

WITNESSES

NAME

SIGNATURE

NAME

SIGNATURE