

RUSH UNIVERSITY MEDICAL CENTER
**REQUEST FOR DISCHARGE PURSUANT TO THE MENTAL
HEALTH & DEVELOPMENTAL DISABILITIES CODE**

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Consent-E
Request for Discharge Pursuant to the
Mental Health & Developmental Disabilities Code



IDN13150171

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label

- A.** Request by an adult voluntarily admitted or a minor 16 years of age or greater who executed an application for admission himself or herself. (Admission ref. 405 ILCS 5/3-400, 3-502; Discharge ref. 3-403)

I request that I be discharged at the earliest appropriate time, not to exceed five (5) days, excluding Saturdays, Sundays and holidays, after the date indicated by my signature, unless I withdraw this request in writing.

- B.** Request by parent, guardian or person in loco parentis for a minor. (Admission ref. 405 ILCS 5/3-503, 3-504; Discharge ref. 3-508)

I request that _____ (Recipient) be discharged at the earliest appropriate time, not to exceed five (5) calendar days after the date indicated by my signature, unless I withdraw this request in writing.

- C.** Request for his or her own discharge by a minor 12 years old or older. For minors 16 years old or older who executed an application for admission himself or herself, use **A.**, above. (Admission ref. 405 ILCS 5/3-503, 3-504; Discharge ref. 3-507)

I request that I be discharged at the earliest appropriate time, not to exceed fifteen (15) days, excluding Saturdays, Sundays and holidays, after the date indicated by my signature, unless I withdraw this request in writing.

- D.** Informal Admission (Admission and Discharge ref. 405 ILCS 5/3-300)

I request that I be discharged at the earliest appropriate time, at any time during the normal daily day-shift hours, beginning with the first day-shift hours of operation after my admission, unless I withdraw this request in writing.

- E.** Administrative Admission of Developmentally Disabled Person (Admission ref. 405 ILCS 5/4-302; Discharge ref. 4-700)

I request that _____ (Recipient) be discharged within three (3) calendar days after the date indicated by my signature, unless I withdraw this request in writing.

I understand that each day is a 24 hour period from the time of this request noted below by the hospital staff.

Recipient or Authorizing Person's Signature

Recipient or Authorizing Person's Printed Name

Date

Print Relationship to Recipient (Recipient/parent/guardian/person in loco parentis)

TO BE COMPLETED BY FACILITY: This request was received at _____ a.m./p.m. on _____ .
(time) (month, date, year)

Staff Person's Signature

Staff Person's Printed Name

Title

BAR CODE LABEL

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I withdraw my request for the discharge of _____ (Recipient)
on _____ at _____ a.m./p.m.
(date) (time)

Recipient or Authorizing Person's Signature

Recipient or Authorizing Person's Printed Name

Date

Print Relationship to Recipient (Recipient/parent/guardian/person in loco parentis)

TO BE COMPLETED BY FACILITY: This request to withdraw discharge request was received at _____ a.m./p.m. on
(time)

(month, date, year)

Staff Person's Signature

Staff Person's Printed Name

Title