FORM 20
MENTAL HEALTH ACT
[Section 37, R.S.B.C. 1996, c. 288]

LEAVE AUTHORIZATION

_____ is released on leave from
first and last name of patient (please print)

_____ _____.
name of designated facility (please print) *date (dd / mm / yyyy)*

The above-named patient's medical certificate expires on _____.
date (dd / mm / yyyy)

CONDITIONS OF LEAVE *(must be completed)*

Note: if above space is insufficient, continue on back of form

☐ It is my opinion that appropriate supports exist in the community to meet the conditions of leave.

I hereby authorize the physician named below, who has agreed to do so, to assume the following responsibilities:

- ☐ clinical care of the patient
- ☐ completion of renewal certificate
- ☐ renewal and modification of conditions of leave
- ☐ recall from leave
- ☐ discharge of the patient

_____ _____
physician's name (please print) *phone number*

_____
physician's address

_____
director's signature

_____
date signed (dd / mm / yyyy)

I confirm that the conditions of my leave have been explained to me.

_____
signature of patient

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