



## CONSENT FOR SURGERY/ PROCEDURE or TREATMENT

1. I hereby authorize Dr. \_\_\_\_\_ and such assistants as may be selected to perform the following procedure or treatment:

\_\_\_\_\_

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I have received the following information sheet:

\_\_\_\_\_

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2. I recognize that during the course of the operation and medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above physician and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun.
3. I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involves risk and the possibility of complications, injury, and sometimes death.
4. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
5. I consent to the photographing or televising of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures.
6. For purposes of advancing medical education, I consent to the admittance of observers to the operating room.
7. I consent to the disposal of any tissue, medical devices or body parts which may be removed.
8. I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical-device registration, if applicable.

9. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
- a. THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN
  - b. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
  - c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-9). I AM SATISFIED WITH THE EXPLANATION.

\_\_\_\_\_  
Patient or Person Authorized to Sign for Patient

Date \_\_\_\_\_ Witness \_\_\_\_\_