

CONSENT FOR OPERATION, DIAGNOSTIC PROCEDURES & OTHER MEDICAL SERVICES

**PERMISSION**

I hereby authorize Dr. \_\_\_\_\_ and his/her associates or assistants may be designated by him/her to perform the following procedure(s):

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If any unforeseen condition arises in the course of the procedure calling upon him/her judgment for procedures in addition to or different from those contemplated, I further request and authorize him/her to do whatever he/she deems advisable.

**EXPLANATION**

Dr. \_\_\_\_\_ has fully explained to me the nature and purposes of the procedure, possible alternative methods of treatment (including no treatment), the risks involved, the possibility of complications, attendant discomfort and expected benefits have been fully explained to me. I acknowledge that no guarantee or assurance has been made to me as to results that may be obtained, and I fully realize that no guarantees can be made.

**CONSENT**

I confirm that I have read and understand the above consent for the procedure(s) outlined under the PERMISSION section of this form and that a thorough explanation was given to me by either the doctor listed above, and/or his/her associates or assistants. I have had the opportunity to ask questions and if questions were asked, they were answered adequately, fully and to my satisfaction.

\_\_\_\_\_  
PATIENT/AGENT/GUARDIAN      DATE      RELATIONSHIP TO PATIENT

PHYSICIAN'S CERTIFICATION: I hereby certify that I have explained the purpose, benefits, complications, risks and alternatives to the proposed procedure, and have fully answered any questions the patient asked.

\_\_\_\_\_  
PHYSICIAN NAME      PHYSICIAN SIGNATURE      DATE