

Patient's Name: \_\_\_\_\_

Date of Surgery: \_\_\_\_\_

## Authorization for Surgery and/or Special Procedure

I hereby authorize Dr. \_\_\_\_\_ to perform the following surgery and/or special procedure:

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I understand that anesthesiologists, nurse anesthesiologists, residents, medical students, physician assistants and/or advanced practice nurses and other qualified staff members and technicians may be in attendance, and/or assisting in the performance, and/or performing significant medical/surgical tasks within the above specified surgery and/or special procedure/treatment. I also understand that in unusual circumstances another physician may substitute for Dr. \_\_\_\_\_.

In addition, I understand that there may be unforeseen circumstances that are encountered while performing the above listed surgery and/or special procedure/treatment that require the assistance of other qualified medical personnel who have not been identified.

I have had explained to me in connection with the proposed surgery/procedure/treatment:

- (i) the nature and purpose of the proposed surgery/procedure/treatment;
- (ii) the foreseeable risks and consequences of the proposed surgery/procedure/treatment, including the risk that the proposed surgery/procedure/treatment may not achieve the desired objective;
- (iii) the alternatives to the proposed surgery/procedure/treatment and the associated risks and benefits to such alternatives; and
- (iv) the reasonably foreseeable risks and alternatives to the transfusion of blood and blood products should I need a blood transfusion.
- (v) the expected follow-up care required after the surgery and/or special procedure.

I have been given the opportunity to ask questions about the proposed surgery and/or special procedure and acknowledge that I am fully informed about the risks, benefits, and follow up care.

Specifically, in obtaining my informed consent to the surgery and/or special procedure, I have been informed of the following reasonably foreseeable risks: \_\_\_\_\_

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or

\_\_\_\_\_ given a handout describing such risks. (Patient's initials: \_\_\_\_\_)

The estimated charge of the procedure absent any unforeseen complications and/or discounts because of my insurance is: \_\_\_\_\_

I understand that the procedure may be filmed as part of my medical record and/or for training purposes. Public dissemination of such films will not be made without my express permission.

Patient Signature:

\_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_