I ACKNOWLEDGE that I have authorized and directed my physician and/or his associates or assistants of his/her choice.

OPERATION/PROCEDURE: The Operation/Procedure to be performed is _____

AGREEMENT TO MEDICAL AND SURGICAL PROCEDURES: The undersigned agrees to the procedures which may be performed including but not limited to laboratory, radiology, medical or surgical treatment or procedures, anesthesia or outpatient services rendered to the patient under the general and special instructions of the patient's physician.

INFORMATION FOR CONSENT: I understand that my physician has determined that the procedure(s) to be performed may be beneficial to me. All surgical operations, diagnostic and therapeutic procedures involve risks of unsuccessful outcomes, complications, injury or even death from both known and unforeseen causes. No warranties or guarantee has been made as to result of care. As a patient I understand I have the right to receive as much information as I need in order to give informed consent or to refuse the recommended course of treatment. Except in emergencies, my physician should describe in language I can understand, the nature of the ailment and the nature of the proposed procedure, the material risks or dangers involved, the alternate courses of treatment or non-treatment, including the respective risk of unfortunate consequences associated with the procedure, and the relative probability of success of the procedure. If I have questions, I understand I am expected to consult with my physician(s) prior to giving my consent to any procedure. I understand I have the right to consent or refuse any proposed procedure prior to its performance.

ACKNOWLEDGMENT OF INFORMED CONSENT: I certify that I fully understand the necessity, nature and risks of the procedure(s) for which I have given consent to my physician, as well as the treatment alternatives; the explanations to any questions I may have had are understood by me; all my questions have been answered; and my consent was given freely, voluntarily and without reservation. I understand that I have the right to refuse medical and surgical procedures and treatment.

ADULT COMPANION: I understand that I am required to have a competent companion accompany me after my procedure and that I will be released to that person's custody and must rely on him/her for my return home and supervision as instructed.

OBSERVER AND/OR FILMING: I agree an observer or clinical or technical representative(s) may be present for my procedure at my physician's direction. I understand an image or a film may be made of all or part of the procedure for research, training, or medical records.

LABORATORY TESTING FOR EXPOSURE TO INFECTIONS: In the event of blood or fluid exposure to medical personnel involved in my care, I authorize and consent to the drawing of my blood for the purpose of conducting HIV or Hepatitis testing. In the event that such exposure does occur, I will be notified and the exposure will be recorded in my medical record. I understand that the test is not 100% reliable and may, in some cases, indicate a false positive or a false negative. A second test may be necessary to confirm results. If there is a positive test result, health care practitioners who were directly responsible for my care will be informed of this result so that proper treatment can occur. My identification and results of the test are confidential and protected against further disclosure to the extent provided by law.

AUTHORIZATION: Having read and fully understood the above, and having received and fully understood information from my physician, I hereby authorize my physician and any of his/her associates, assistants, or students to perform the above-named procedure(s) and to provide additional services as may be deemed medically reasonable and necessary, including, but not limited to:

1) Those resulting from conditions or discoveries, which in the opinion of the professional make a change or extension advisable.
2) Administration and maintenance of anesthesia considered necessary or advisable by the professional responsible for such services.
3) The implant of medical devices.
4) Services involving pathology and radiology.
5) Related follow-up care.

I hereby acknowledge the above statements.

Patient	Date and TIME	Witness	Date and TIME

(In the event the patient is a minor, unconscious, or is otherwise not competent to acknowledge an understanding due to physical or mental condition, complete the following.)

If patient's personal representative, state relationship and authority:

Patient's Representative	Date and TIME	Witness	Date and TIME

PLACE PATIENT I.D. LABEL HERE