

I, the undersigned, do hereby authorize Dr. _____ and / or such assistants as may be selected by him / her to perform the following surgical procedure(s):

upon _____ (Name of Patient or Myself)

1. **UNDERSTANDING:** The procedure(s) listed above has been fully explained to me and I fully understand the nature of the procedure as well as the risks, benefits, and alternatives to the proposed surgery. I understand that surgery is not an exact science and no guarantees have been made to or implied to me.
2. **RISKS:** I understand that any surgical procedure carries inherent risks. These risks include but are not limited to risks from anesthesia (including death), perforation, puncture, laceration or cut to organs or tissues, significant infection, bleeding and tooth damage. It is impossible to list every possible complication so the above lists are incomplete.
3. **ADDITIONAL PROCEDURES:** If my doctor discovers a different, unexpected condition during my surgery, I authorize him / her to perform such additional or different procedures as considered necessary or advisable.
4. **DRUGS AND ANESTHESIA:** The administration of drugs and anesthesia, even local anesthesia, involves risks including rare risk of death due to unusual reaction. I consent to the use of such drugs as may be necessary under the direction and supervision of the anesthesiologist / surgeon.
5. **BLOOD, TISSUES, BLOOD PRODUCTS:** I authorize and consent to any blood test (except HIV) or specimen / tissue evaluations deemed necessary by my surgeon or anesthesiologist. I understand that the surgery center may retain, preserve, or dispose of any specimens / tissues removed from my body in accordance with usual and customary practice. I consent to the transfusion of blood or blood products if necessary.
6. **PHOTOGRAPHS:** I consent to the photography / videotaping of my surgical procedure and for the use of these in medical education, publication, and / or research, provided I would not be identified by name.
7. **TRANSFER TO ANOTHER FACILITY:** I understand that the surgery is intended to be performed on an outpatient basis. I consent to my transfer to a hospital or other healthcare facility should my physician(s) deem it advisable or necessary. I also authorize the surgical center to arrange transfer including release of my medical record.
8. **OBSERVERS:** With the approval of my physician, I consent to the admission of observers (such as medical students) in the operating room for the purpose of advancing medical and nursing education, as well as persons required for technical support.
9. **TRANSPORTATION:** I understand that I am scheduled to go home after surgery and I must have a responsible adult drive me home.
10. **ADDITIONAL INFORMATION:** _____

I HAVE READ (or it has been read to me) AND UNDERSTAND THIS CONSENT FORM. ALL MY QUESTIONS HAVE BEEN ANSWERED. I FREELY CONSENT TO THIS SURGERY.

Patient Signature _____ Date _____ Time _____

Parent/Guardian Signature _____ Witness _____

Reason patient unable to sign: _____

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| I certify that I fully explained the operation(s) and / or procedures and medical alternatives to the patient and answered all questions asked by the patient. | |
| Physician's Signature _____ | Date _____ |

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