MID-ATLANTIC SURGERY PAVILION

NAME:_____ DATE: _____ TIME:_____

I hereby authorize _____ and whomever he/she may designate as assistants to perform upon myself the following operation: _____ and if any unforeseen condition arises in the course of the operation calling in his/her judgment for procedures in addition to or different from those now contemplated, I further request and authorize him/her to do whatever he/she deems advisable. This may include transfer to a higher level of medical care for acute conditions. In the event of such transfer, I authorize my date of service records to accompany me and further authorize the release of the hospital discharge summary to Mid-Atlantic Surgery Pavilion.

The nature and purpose of the operation, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained. I have received a copy of the Patient's Rights and Responsibilities, the Surgical Procedures Risks and Conditions of Admission, the ownership disclosure, and information on advance directives and understand them. I understand my financial liability and responsibility with regards to this procedure. I hereby authorize Mid-Atlantic Surgery Pavilion to bill my insurance company which may include release of medical information to process my claims. I also authorize payment to be made directly to Mid-Atlantic Surgery Pavilion.

I consent to the administration of anesthesia by a Board Certified Anesthesiologist or a Certified Registered Nurse Anesthetist.

I consent to the disposal by authorities of the Mid-Atlantic Surgery Pavilion any tissue which may be removed. For the purpose of advancing medical education, I consent to the admittance of observers to the operating room. I consent to the photographing or televising of my operation for medical or educational purposes provided my identity is not revealed.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO OPERATION, THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND ALL APPLICABLE PARAGRAPHS, IF ANY WERE STRICKEN BEFORE I SIGN.

_____ _____

(Witness) (Signature of Patient)

If patient is unable to sign or is a minor complete the following. Unable to sign because:

_____

_____ _____

(Witness) (Closest Relative or Legal Guardian)

I have discussed the procedure with the patient. _____

(Surgeon Signature)