DISCLOSURE AND CONSENT
Medical and Surgical Procedures

***TO THE PATIENT*: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.**

I (we) voluntarily request _____,
name, credential (e.g. MD/DO, NP, DDS, etc.)
as my physician or health care provider, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me (us) as: _____
_____
_____.

I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures_____
_____
_____.

I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician or health care provider, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (we) (do) (do not) consent to the use of blood and blood products as deemed necessary. I (we) understand that the following risks and hazards may occur in connection with the use of blood and blood products:

1. Serious infection including but not limited to Hepatitis and HIV which can lead to organ damage and permanent impairment.
2. Transfusion related injury resulting in impairment of lungs, heart, liver, kidneys, and immune system.
3. Severe allergic reaction, potentially fatal.

I (we) understand that no warranty or guarantee has been made to me as to result or cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure: _____
_____
_____
_____.

I (we) have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we) certify this form has been fully explained to me (us) , that I (we) have read it or have had it read to me (us), that the blank spaces have been filled in, and that I (we) understand its contents.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (signature required):

_____

DATE: _____ TIME: _____ A.M./P.M.

WITNESS:

_____
Signature

_____
Name (Print)

_____
Address (Street or P.O. Box)

_____
City, State, Zip Code