Surgical Consent Form

1. I,_____, hereby authorize Dr. _____ and whomever he/she may designate as his/her assistants to perform the following surgery/treatment/diagnostic procedure:

   _____

   _____

   _____
2. I authorize him/her to do whatever he/she deems necessary if any unforeseen condition arises in the course of the surgery/treatment/diagnostic procedure calling, in his/her judgment, for procedures in addition to or different from those now contemplated.
3. Students, health care industry representatives, surveyors, or others may watch the procedure or observe my care throughout my stay. This must be approved by the facility.
4. The risks/benefits alternatives and consequences associated with anesthesia have been explained to me, and I consent to the administration of anesthesia as deemed advisable.
5. I consent to the disposal of any tissue, parts or organs which may be removed.
6. I consent to the recording or filming of the procedure, care and/or services rendered, limited to the internal organizational purposes of medical education or performance improvement. I understand that the recording or other images will be kept confidential and subject to the same privacy guidelines as my medical record.
7. The nature and purpose of the surgery/treatment/diagnostic procedure, including risks, benefits, alternatives, consequences, potential complications and alternative treatments have been explained to me by the physician(s) and I understand no guarantee or assurance has been made as to the results that may be obtained.
8. I understand the nature of the surgery/treatment/diagnostic procedure to be as stated above.
9. In the very rare event that a staff personnel is exposed to my blood or body fluids, my blood will be drawn and tested for HIV and hepatitis. The results of these tests will be disclosed only to the exposed health care worker, Employee Health services of this facility, the State Health Department, and my physician, if indicated.

I certify that I have read and fully understand the above authorization or it has been read to me and I understand it, and that all blanks or statements requiring insertion or completion were filled out and/or statement number _____ were crossed out before I signed.

Patient's Signature	Date
Signature of Parent/Legal Guardian if Patient is a Minor/Power of Attorney	Time ☐ a.m. ☐ p.m.
Relationship to Patient	
Witness	

Phone Consent

Person Giving Consent	Relationship	
Witness #1	Date	Time ☐ a.m. ☐ p.m.
Witness #2	Date	Time ☐ a.m. ☐ p.m.

☐ **Educational material provided.**