



### Consent For Operation and/or Procedure

I hereby give authorization and consent to (Attending Physician) Dr. \_\_\_\_\_, Dr.(s) \_\_\_\_\_

and the Massachusetts Avenue Surgery Center and its staff to provide such surgical and other related procedures and therapeutic services as they may consider necessary, to include the following operation and/or procedure described as: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Describe Operation and/or Procedure

Patient Verification of Surgery Site		
Left	Right	Bilateral
	Anterior	Posterior
Patient Initials _____		

upon (Name of Patient) \_\_\_\_\_

The nature, intended purpose, benefits, significant foreseeable risks, complications and consequences of such operation/procedure, as well as the alternatives if the above operation/procedure is not performed, have been explained and discussed with me by (Name of Physician) \_\_\_\_\_.

I give this permission with full knowledge and understanding thereof, I understand that medicine is not an exact science and that there is the possibility that the operation/procedure may not have the benefits or results intended. I am also aware that there are always risks and dangers to life and health associated generally with surgery, use of medication, medical procedures and treatments which can cause adverse consequences not ordinarily anticipated in advance, but I give this permission with full assent nevertheless.

It has been explained to me and I understand that during the course of the operation/procedure, unforeseen conditions may be revealed or encountered which necessitate surgical or other procedures in addition to, or different from, those contemplated. I therefore request and authorize the above named physician or his/her designees to perform such additional surgical or other procedures as are deemed necessary or desirable including possible transfer of myself and records to another facility.

I further grant permission for the use of such tissues and/or organs, as it may be necessary to remove during said operation/procedure for purposed of pathological diagnosis and thereafter for the advancement of medical knowledge and/or education, and their disposal, at this Center or at such other institutions as this Center may designate.

I consent to the photographing, videotaping, televising or other observation of the operation/procedure as may be purposeful for the advancement of medical knowledge and/or education, with the understanding that my/the patient's identity will remain confidential.

I consent to the presence of a visitor or visitors, which may include a visiting physician or vendor representative whose presence has been requested by the physician. I understand that the visitor(s) will, at all times, be under supervision and direction of my physician and other Center personnel, and shall agree to abide by all relevant Center policies and procedures.

I confirm that I have read and fully understand the above and have been given the opportunity to ask questions and all my questions have been answered satisfactorily.

I represent to my/the patient's physician and the Massachusetts Avenue Surgery Center that I am eligible to give this consent.\*

Signature of Patient/Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

\*Note if the patient is under 18 years of age, the permission of the patient's parent or legal guardian must be obtained, unless the patient has married or is the parent of a child.

Witness \_\_\_\_\_ Date \_\_\_\_\_

Physician \_\_\_\_\_ Date \_\_\_\_\_