1. I request and authorize the performance upon _____
of the following invasive, surgical, technical procedure or medical treatment:

_____

_____

_____

to be performed at the Hospital by Dr. _____ or his designated agent(s).

2. I hereby acknowledge that Dr. _____ , has explained to me my condition, proposed surgical procedure or medical treatment and anticipated benefits, the material risks and complications in the proposed treatment plan and recuperation, alternative forms of treatment, the material risks and anticipated benefits of alternative procedures, treatments or therapies, the chances of failure, death, and the risks of unplanned injuries to organs, nerves, or blood vessels, to include accidental puncture, laceration, and tearing of other internal organs and subsequent hemorrhage and need for additional surgery to repair. I authorize and consent to this procedure being performed upon me by my physician. I have been informed that other surgeons, residents and surgical assistants may perform significant surgical tasks as permissible by state law and under the direct supervision of my physician/surgeon. I understand the practice of medicine is not an exact science. My request and consent for this treatment is the result of my discussion with my physician. I have had the opportunity to ask questions, and they have been answered to my satisfaction.

3. I recognize that during the course of this procedure, unforeseen conditions may arise that could require additional or different procedures not described in Paragraph 1. I, therefore, request and authorize that the above named physician and/or agent(s) perform such procedure(s) as necessary. This authority shall extend to remedying conditions that are not known to the above named doctor at the time of the procedure referenced in Paragraph 1.

4. I consent to sedation for this procedure as directed and discussed by my physician. Every type of sedation has risks and hazards. Unexpected reactions may occur. These include reactions to medications, aspiration, pneumonia, local inflammation, and respiratory or cardiac arrest which can lead to heart, lung, liver, kidney or brain damage and death. These complications are very uncommon and your physician will try to protect you from these risks, but no guarantees as to the outcome of the sedation can be made.

5. I acknowledge that no guarantee has been given regarding the anticipated results of this surgery/procedure.

6. I consent to photographs/videography taken at the direction of my physician during the course of any such operation or procedure. I understand that the photographs/video are not retained as part of my medical record unless directed by my physician.

7. I consent to the presence of a manufacturer's representative in the operating/procedure room if requested by my physician.

8. Further, I authorize the Hospital and/or its agents to preserve for scientific or education purposes, or for use as grafts in living persons, or to otherwise dispose of, any organs, tissues, limbs or other body parts surgically removed, in accordance with customary medical practice. I further relinquish any right to any tissue, organ or graft removed from my person.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE ABOVE.

_____	_____	_____
Patient or Authorized Representative	Date	Time
_____		
Relationship		
_____	_____	_____
Witness Signature	Date	Time