

Consent: I authorize and direct Dr. _____ and/or his/her associates to perform the above named procedures upon me. I have reviewed my clinical condition with my physician including the anticipated benefit to be obtained from such procedures, the risks of the procedures and alternatives. While no guarantee has been made as to the results of any planned treatment, I understand that this is administered in the best judgment of my physician to benefit me. I also understand that physicians in training (residents), healthcare industry representative (vendor), and/or other qualified personnel may participate in this procedure, under the supervision of my physician, at a level of involvement deemed appropriate by my Attending Physician. I further understand that my attending physician will be present during the key parts of the procedure but may not be present for the entire procedure.

Medications & Procedures: I further understand that with any procedures, administration of medications including anesthetics, includes certain risks. I understand that consideration of the risks is weighed into the medical decision that is made by my physician in order to benefit me.

Blood Products: I further understand that with any procedures or an unforeseen condition may arise that may require the transfusions of blood/blood products. I request and authorize my physician, in his or her best judgment, to direct any further therapeutic means to improve my condition. I understand that I can also refuse transfusion of blood products.

Additional Services: In the course of the above named procedure, certain unforeseen conditions may arise that may require additional services including operations, procedures, administration of medication, and invasive monitoring techniques. I request that my physician, in his or her best judgment, direct any further therapeutic means to improve my condition.

Scientific and Educational Purposes: I do hereby authorize and direct my physician or the pathologist to examine, retain for scientific and/or educational purposes, or dispose of all such tissues, organs, or bodily fluids that shall be removed by operation or biopsy performed upon me. I understand that my identity will be concealed and my privacy maintained.

Consent to Videotape/Photograph: I understand and consent that certain procedures are routinely videotaped or photographed at the request of the physician and may be used by him/her in the diagnosis and documentation of medical conditions and/or purpose of medical education. I further understand that my identity will be concealed and my privacy maintained if the material is used for educational purposes.

Advance Directives: I understand advance directives are not honored in the outpatient setting except as agreed to by physician and patient.

Sharp Instruments: I understand this procedure will require the use of sharp instruments. Therefore, in the event that a member of the clinical staff punctures his/her skin, I give consent to staff to perform all necessary serologic testing for the HIV antibody, any other blood borne infections, and disclose to appropriate personnel and as may be otherwise required by state or federal law.

I have discussed the procedure named above, including its material risks, and benefits, including potential problems related to recuperation, and side effects related to alternatives including the possible results of not receiving care, treatment, and services based on the available clinical evidence as determined by the responsible practitioner's clinical judgment. The patient/family understands and acknowledges that questions were answered to their satisfaction and requests to proceed.

IF THE PATIENT IS A MINOR or UNABLE TO SIGN, COMPLETE THE FOLLOWING (print all information in this section):

Name (Print): _____ Address: _____

Relationship: _____ Patient cannot sign because: _____

Father and/or Mother _____ Time _____ Date _____ Guardian/ Other Person _____ Time _____ Date _____

Physician/Dentist/Practitioner Signature _____ Time _____ Date _____ Witness _____ Time _____ Date _____

_____ Time _____ Date _____

Translation (if necessary) – The foregoing document has been accurately and completely translated, with assistance by an approved translator or approved translation service, to the signatory identified above in the patient's/patient representative's preferred language. The patient/patient representative indicated their understanding of all terms and conditions and acknowledged his/her agreement by signing this document in my presence.	Preferred Language if Not English:
	Translators Name/ID#