SAC HEALTHSYSTEM

Authorization for Operation or Special Procedure

Name of Patient: [redacted]

Name of Medical [redacted]

Operation/Special [redacted]

I understand the explanations given to me. I have had the opportunity to ask questions regarding common risks, complications, and benefits of this procedure. Alternate treatment possibilities have been explained to me.

I hereby consent to the performance of this operation or special procedure named above by the Medical Provider, with whatever anesthesia, treatment, dressing, medication or transfusion is necessary. I also authorize the SAC Health System clinic to preserve for diagnostic, scientific or teaching purpose or otherwise dispose of the tissue or part removed.

[redacted]

Patient Signature

11/17/20
Date

Other Signature

Date

_____Parent of Minor
_____Guardian or Conservator
_____Other (Specify)_____

Witness Signature

Date

FOR CLINIC USE

Medical Provider's statement: I have explained the common risks, complications, and benefits for the above named procedure as well as alternative treatment plans with the above named patient and agree to proceed as authorized.

[redacted]

Medical Pr

11/17/20
Date

PATIENT IDENTIFICATION

NAME: _____
D.OB : _____
MEDICAL RECORDS: _____