Advanced Women's Healthcare

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Obstetrics | Gynecology | Urogynecology | Minimally Invasive Surgery | Infertility

General Consent For Medical/Surgical Procedures/Interventions

PATIENT NAME: ____________________________________ DATE OF BIRTH: __________________

You have been given information about your condition and the recommended surgical, medical, or diagnostic procedure(s). This consent form is designed to provide a written confirmation.

AUTHORIZATION: I authorize performance on the patient of the following medical procedure or intervention under the direction, supervision, and authority of:

____

Description of Procedure:

____

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I am aware that there may be risks or complications that could occur. I also understand that during the course of the proposed procedure, unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed.

I acknowledge that no guarantees or promises have been made to me concerning the results of this procedure or any treatment that may be required as a result of this procedure.

I voluntarily consent to the performance of the procedure described above by my clinician or those who work with him/her.

____ ______________________
Patient/Legal Representative Signature Date

____ _______________________
Witness Signature Date

____ ________________________
Physician Signature Date