
AUTHORIZATION & CONSENT FOR SURGICAL, MEDICAL, AND/OR DIAGNOSTIC PROCEDURES

The Informed Consent process is to establish an understanding between you and your Physician(s) and to obtain your authorization and consent to a surgical, medical, and /or diagnostic procedure ("Proposed Care"). Read this form carefully. Ask questions of your Physician(s) before you sign this form. **This Authorization & Consent is valid thirty (30) days from date of signature.**

1. My Physician(s) has/have recommended the following described Proposed Care at BroMenn Healthcare:

2. Dr. _____, ("my Physician" or "your Physician"), or associated physicians in practice ("Associates") will perform the Proposed Care. Physicians other than my Physician or his/her Associates, including but not limited to residents, fellows, and/or other physicians-in-training or student, non-physician clinicians at BroMenn Healthcare, may assist with the Proposed Care or may be performing important surgical tasks under the direct or indirect supervision of my Physician or his/her Associates. Significant portions of the Proposed Care may be performed by medical residents, teaching fellows, physician-in-training, or assistants aiding my Physician or his/her Associates. Specialized medical services such as anesthesia, radiology and pathology may be performed by other physicians or medically trained personnel who have privileges to practice at BroMenn Healthcare. Medical residents, teaching fellows, physicians-in-training, and student, non-physician clinicians will only be performing those tasks within their individual skill sets and under the direct or indirect supervision of my Physician or his/her Associates.

3. My Physician or his/her Associates has/have fully explained to my satisfaction the nature of the Proposed Care together with the risks and benefits associated with the Proposed Care, the failure to treat my condition and any available, feasible treatment alternatives. I understand the reason for the Proposed Care is:

4. My Physician or his/her Associates has/have fully explained to me the diagnosis of my condition, the nature of the Proposed Care and the material risks, complications and adverse outcomes potentially associated with the Proposed Care, including but not limited to, death.

5. My Physician or his/her Associates has/have also told me that sometimes complications develop in the course of treatment. I have told my Physician or his/her Associates to proceed with whatever his/her best medical judgment leads him/her to believe should be done in case of any complications that might develop, including the use of additional medical personnel should that be deemed to be appropriate.

6. I understand my Physician or his/her Associates may utilize the technical support of a sales representative. I consent to this sales representative being present during my Proposed Care. Yes ___ No ___ Not applicable ___

7. I consent to the examination, disposal or retention of any of my tissues, bodily fluids or body parts which may be removed from my body, with the following exception(s): _____. Yes ___ No ___ Not applicable ___

8. I consent to the photography of the Proposed Care, including appropriate portions of my body, for medical, scientific or educational purposes, provided attempts are made to protect my identity. Yes ___ No ___ Not applicable ___

9. I consent to the observation of my Proposed Care by Observers who are approved by BroMenn Healthcare and my Physician (or his/her associates). "Observers" shall mean individuals who are not participating in the provision of the Proposed Care but are simply observing for approved educational purposes. Yes ___ No ___ Not applicable ___

10. I understand this consent for the Proposed Care may be revoked by me at any time before the Proposed Care is performed.

I hereby authorize and consent to the Proposed Care described above.

Signature: _____ Print Name: _____ Date: _____ Time: _____ am/pm
(Patient/Parent/Authorized Person)

If signed by other than patient, indicate relationship: _____ Date: _____ Time: _____ am/pm

Signature: _____ Print Name: _____ Date: _____ Time: _____ am/pm
(Witness to signature)

Signature: _____ Print Name: _____ Date: _____ Time: _____ am/pm
(2nd witness of telephone consent)

DOCUMENTATION OF PHYSICIAN SIGNATURE & INFORMED CONSENT AFFIRMATION

My signature below affirms that prior to the time of the Proposed Care, I explained to the patient and/or to the authorized person the nature of the Proposed Care, treatment alternatives and consequences of not doing the procedure, and the potential risks and benefits of each.

Signature: _____ Print Name: _____ Date: _____ Time: _____ am/pm
(Physician)