

DR. MATURE PRACTITIONER; DPM

[Podiatrist]

1234 Last Generation Avenue

Old Field, MD 12345

Authorization for Surgery

Patient: _____

Date: _____

As the patient, you have both the right and obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, BUT IT IS YOUR DECISION WHETHER TO UNDERGO SURGERY.

1. I hereby authorize Dr. _____, and whomever he/she may designate as his/her assistants, to perform upon me the following operation:

2. I consent to the performance of operations and procedures in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions, which the above named doctor or his associate may consider necessary or advisable in the course of the operation.
3. The nature and purpose of the operation, alternative methods of treatment (including no treatment), the risks and possible complications such as but not limited to POST OPERATIVE INFECTION, DELAYED OR NON-HEALING, PAIN, NUMBNESS, PERSISTENT POST OPERATIVE SWELLING, EXCESSIVE AND/OR PAINFUL SCAR FORMATION, RECURRENCE OF THE CONDITION, AND THE POSSIBLE NEED FOR ADDITIONAL SURGICAL PROCEDURES, have been fully explained to me.
4. I acknowledge that I have received no guarantee concerning the outcome of the surgical procedure to which I am consenting.
5. I consent to the administration of anesthesia and to the use of such anesthetics as he/she may deem advisable.
6. I consent to the administration of radiologic procedures (X-rays), the taking of tissue samples or parts for laboratory testing and such additional services or testing as may be necessary.
7. I consent to the disposal of any tissues or parts which may be removed during the surgical procedure.
8. I have informed my podiatrist of allergies to the following medications: _____
_____.
9. I am required to take antibiotics prior to having a procedure performed ____ Yes ____ No
10. I certify that I have read and fully understood that above consent to operation, that the explanations therein referred to were made, and that **all blank spaces have either been completed or crossed off prior to my signing.**

Patient Signature _____

Date _____

Witness _____

Date _____