SFASC SURGERY CENTER OF SANTA FE
CONSENT for SURGERY or PROCEDURE

Patient Name_____

Surgeon/s_____

Consent to surgery or procedure: I acknowledge that I have authorized and directed my surgeon (or his/her assistants of choice) to perform the following operation or procedure on me, and to administer any necessary medications chosen, to provide any additional services that he/she deems necessary or advisable on the basis of findings during the course of said operation, including but not limited to services involving pathology, and the disposal of removed, unnecessary tissue.

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Risks/Benefits: Just as there may be benefits to the procedures(s) proposed, such as improved vision, I also understand that medical and surgical procedures involve risks. These risks include allergic reaction, inflammation, bleeding, blood clots, infections, adverse side effects of drugs, blindness and even loss of bodily function or life. I also realize that there may be other risks associated with the procedure(s) proposed for me.

Complications: I am aware that in the practice of medicine, other unexpected risks or complications, not discussed, may occur. I also understand that during the course of the proposed procedure(s) unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed.

Alternatives: The alternatives to this surgery include not having the surgery or deferring the surgery. For my particular situation there may be other alternatives – if so, they are listed here: _____

Consent to transfer: I understand that the surgery or procedure performed on me at SFASC will be done on an outpatient basis and the SFASC does not provide over-night patient care. If my attending practitioner shall find it necessary or advisable to transfer me to a hospital, I consent and authorize the employees of SFASC to arrange for and affect the transfer.

Authorization to release information: The undersigned authorizes SFASC and other physicians rendering service, for example, Anesthesiologists, Pathologists, Radiologists, to release medical or other information about the patient which may be necessary for the completion of insurance claims, review of services, or receipt of benefits. Such information may include current medical records.

Personal valuables: SFASC is not responsible for personal property. SFASC asks that you leave all valuables with your driver. Only essential items may be brought back into the Pre-Operative Area. Examples of such items include reading glasses, hearing aids, medical devices, and assistive devices.

Observers: I hereby authorize observers to be present during my surgery or procedure for the purposes of their medical training/education/business or technical purposes for the SFASC. The observer has no role or responsibility in performing the procedure on me. I release SFASC, its personnel, and the physician from any legal responsibility, which may result from the above named person's presence in the Operating Room.

Photographing or videotaping: I consent to the photographing or videotaping of the surgery or procedure to be performed for medical or educational purposes, provided my identity is not revealed by the pictures or by descriptive texts accompanying them. The photographs or videos will become the property of SFASC and/or its physicians.

Certification: I acknowledge that I have read (or have had this consent read to me) and fully understand the explanations given and that all blanks requiring completion were filled in before I affixed my signature. My signature below acknowledges that: I voluntarily give my authorization and consent to the performance of the procedure(s) described above by my physician and his/her associates. A photocopy of this authorization shall be considered as effective and valid as the original.

Patient Signature (or authorized representative and relationship to patient)

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Witness _____Date _____Time _____