Authorization for Surgery

Patient: _____

As the patient, you both have the right and obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, BUT THIS IS YOUR DECISSION WHETHER OR NOT TO UNDERGO SURGERY.

1. I hereby authorize Dr. Franklin R. Polun and whomever he may designate as his assistant to perform upon me the following operation:
   _____
   _____
   and if, in his discretion, during the course of such operation other or different operative procedures appear advisable, to perform such other or different procedures as they have been specifically authorized by me.

2. The nature and purpose of the operation, possible alternative methods of treatment (including no treatment), the risk involved and the possibility of complications have been fully explained to me. I acknowledge that no guarantee or assurance has been made about the results that may be obtained.

3. I consent to the administration of anesthesia and to the use of such anesthetics as deemed advisable, with the exception of:_____

4. I consent to the administration of radiological procedures (x-rays), the taking of blood and urine samples for laboratory testing and such additional services or testing as may be necessary.

5. I consent to the use of transfusion of blood and blood products as deemed necessary and will not hold my doctor responsible for any possible adverse effects as a result of such transfusion.

6. I consent to the use of the disposal of any tissues or parts which may be removed during the surgical procedure.

7. I have informed my doctor of allergies to the following:
   _____

8. I UNDERSTAND THAT THE USE OF DRUGS, including alcohol, prescribed or otherwise; past and present abuse of alcohol or drugs on the existence of conditions such as allergies to medications, pregnancy, epilepsy, herpes, AIDS, and others not disclosed by me to the doctor or his associates/assistants may affect his recommendation as to treatment or alternative forms of treatment and I ASSUME ALL RISKS which may exist as a result of my failure or refusal to disclose such matters prior to treatment. It is understood that this paragraph applies to conditions resulting from having consumed food and drink six hours prior to surgery, other than as prescribed by my doctor.

9. I certify I have read, or have had the form read and explained to me, and that I fully understand its contents. I have been given ample opportunity to ask questions and that my questions have been answered to my satisfaction. All blanks or statements requiring completion were completed and all statements to which I do not approve were stricken before I signed this form.

_____ _____

Signature of Patient or legal representative *Witness*

_____ _____

If legal representative, relationship to patient *Date*