

# REQUEST FOR MEDICAL/SURGICAL PROCEDURE RELEASE

## (Informed Consent)

I, \_\_\_\_\_, do hereby consent and authorize the following described medical procedures upon me by or under the direction of Hugh Chatham Health providers, assistants and associates:

Procedure(s): \_\_\_\_\_  
\_\_\_\_\_

- I have discussed possible complications with my provider and/or staff regarding this procedure and understand the information provided.
- I request the administration of such anesthetics as may be considered necessary or advisable by the physician and/or the nurse practitioner.
- The nature and the purpose of the procedure, possible alternative methods or treatment and the risks involved have been fully discussed with me by my provider. I understand that there can be no guarantee of outcome with any medical procedure and acknowledge that no guarantee has been made to me with regard to this procedure/procedures.
- I further agree that photographs and a narrative of my case may be utilized for medical education or science, including publication in professional journals and medical books. However, any publication of these photographs or narrative will exclude my name so as to protect my identity.
- I further consent to the disposal of tissue or parts removed at the time of the operation.
- I further acknowledge that I have been given full opportunity to discuss the matter contained herein with my provider and assistants, or replacements and that I understand the information provided.

“Time Out” Performed:  Yes  No

\_\_\_\_\_  
Signature of Patient Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian Date

\_\_\_\_\_  
Signature of Witness Date

I have personally explained the above information to the patient or the patient's authorized representative.

Patient's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Provider Name Date

Patient's Chart Number: \_\_\_\_\_

\_\_\_\_\_  
Provider Signature Date

Patient's ID: \_\_\_\_\_

