



# Plastic Surgery & Dermatology Associates (PSDA)

## AUTHORIZATION FOR PERFORMANCE OF SURGICAL OPERATIONS AND OTHER PROCEDURES

NAME: \_\_\_\_\_  
PERSONAL MD: \_\_\_\_\_  
MD ADDRESS: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ a.m./p.m.

1. I hereby consent to the performance upon myself or (name of patient) \_\_\_\_\_  
of \_\_\_\_\_

(Nature of operation or procedure – to be completed before signature of patient is requested. Describe procedure in layman’s terms; do not use abbreviations).

This operation or procedure is to be performed by Dr. \_\_\_\_\_  
and/or such assistants as may be selected by him to treat the condition or conditions which appear indicated by the diagnostic studies already performed.

2. It has been explained to me, and I understand, that during the course of the operation unforeseen conditions may be revealed that require an extension of the original procedure(s) or operation(s) other than those set forth above, in Section 1. I therefore authorize and request that the above-named surgeon, his/her assistants or designees, perform such surgical procedure(s) as he/she deems necessary and desirable in the exercise of his or her professional judgment, including the administration of general and local anesthetics, contrast dye, and the use of x-rays.
3. I have been informed of the most common risks and consequences associated with the procedure described above.
4. I have been informed of alternatives to the procedure(s) to be performed, if any, and the most common risks and consequences associated with any such alternatives.
5. I have been informed that there are risks such as loss of blood, infection, cardiac arrest, etc., that are associated with the performance of any surgical procedure. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge and understand that neither the surgeon who performs the above operation(s) or treatment, and no guarantees have been made concerning the results of the operation(s) or procedure(s) to me or the patient if other than me.
6. I consent to the disposal, use or examination of any bones, organs, tissues, fluids or parts which it may be necessary to remove.
7. I consent to taking of any photographs in the course of this treatment for the purpose of advancing medical knowledge.
8. I consent to the presence of additional people during the procedure to observe the procedure to provide technical consultation to the physician. My physician has explained to me why additional individuals will be present.

I HAVE HAD THE OPPORTUNITY TO ASK A PHYSICIAN QUESTIONS REGARDING ANY CONCERNS I HAVE ABOUT THIS PROCEDURE(S) AND I HAVE HAD MY QUESTIONS ANSWERED TO MY SATISFACTION.

\_\_\_\_\_  
Signature of Patient or

\_\_\_\_\_  
Signature of Person Authorized to Consent for Patient/Relationship

\_\_\_\_\_  
Signature of Witness to Consent

\_\_\_\_\_  
Print Name of Witness