Coddington Medical Family Practice, LLC

AUTHORIZATION FOR AND CONSENT TO SURGERY, SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURES

PATIENT NAME: ____

PROPOSED PROCEDURE: ____

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I HAVE BEEN ADVISED BY MY PHYSICIAN THAT THE PROPOSED PROCEDURE(S) LISTED ABOVE MAY BE BENEFICIAL IN THE DIAGNOSIS OR TREATMENT OF MY CONDITION; THEREFORE, I AUTHORIZE MY PHYSICIAN, DR. ___________________

(AND ANY ASSISTANTS DESIGNATED BY MY PHYSICIAN), TO PERFORM THE PROCEDURE(S) LISTED ABOVE AND TO DO ANY OTHER PROCEDURE(S) THAT MY PHYSICIAN MAY DEEM NECESSARY DURING THE ABOVE PROCEDURE(S) SUBJECT TO THE FOLLOWING LIMITATIONS: __________________________________

THE NATURE AND PURPOSE OF THIS PROCEDURE(S) HAS BEEN EXPLAINED TO ME BY MY PHYSICIAN AND NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME AS TO THE RESULTS THAT MAY BE OBTAINED. I HAVE BEEN ADVISED THAT SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURES ALL INVOLVE RISKS OF COMPLICATIONS FROM BOTH KNOWN AND UNKNOWN CAUSES. I UNDERSTAND THAT, EXCEPT IN CASES OF EMERGENCY OR EXCEPTIONAL CIRCUMSTANCES, THESE PROCEDURES ARE NOT PERFORMED UNLESS I HAVE HAD AN OPPORTUNITY TO DISCUSS THEM WITH MY PHYSICIAN.

I UNDERSTAND THAT I HAVE THE RIGHT TO CONSENT OR REFUSE ANY PROPOSED PROCEDURE. I AGREE THAT THE PROPOSED PROCEDURE(S) HAS BEEN SATISFACTORILY EXPLAINED TO ME AND THAT I HAVE ALL THE INFORMATION THAT I DESIRE. THEREFORE, I HEREBY GIVE MY AUTHORIZATION AND CONSENT.

PATIENT SIGNATURE: ____

WITNESS: ____

DATE: ___________________________ **TIME:** ______________________________