Huntington Hospital

Authorization for and Consent to Surgery, Care, Treatment, Special Diagnostic or Therapeutic Procedures

1. I, (Patient's name),_____
hereby authorize and direct the following Practitioner(s) to perform the following surgery, care, treatment, special diagnostic or therapeutic procedures upon me:

Practitioner(s): _____

Procedure(s)_____

_____

_____

and to perform any other surgery, care, treatment, special diagnostic or therapeutic procedures that in their judgement and due to unforeseen circumstances may be advisable for my well-being.
The surgery, care, treatment, special diagnostic or therapeutic procedures will be performed by the physician(s) stated above.

2. I acknowledge that Dr.(s) _____ has/have explained to me that the surgery, care, treatment, special diagnostic or therapeutic procedures may carry the risk of unsuccessful results, complications, injury or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to a result or cure. I understand that I have the right to be informed of:
   - The nature and purpose of care, treatment, services, medications, interventions, or procedure,
   - Potential benefits, risks, or side effects, including potential problems related to recuperation,
   - The likelihood of achieving care, treatment or service goals,
   - Reasonable alternatives to proposed care, treatment and service,
   - Relevant risks, benefits and side effects relating to alternatives, including the possible results of not receiving care, treatment and services,
   - When indicated, any limitations on the confidentiality of information learned from or about the patient,
   - Whether stated physician(s) has/have any independent medical researcher economic interests related to the performance of the surgery, care, treatment, special diagnostic or therapeutic procedures.

   Except in cases of emergency, the surgery, care, treatment, special diagnostic or therapeutic procedure(s) is not performed until I have had the opportunity to receive this information and have given my consent. I have the right to refuse any proposed surgery, care, treatment, special diagnostic or therapeutic procedures at any time prior to its performance and I have a right to know the potential risks of such refusal. My refusal will not impact my access to current or future health care.

3. By my signature below, I hereby give my consent to the above stated physician(s), and his/her associates, to provide any additional services as he/she/they deem reasonable and necessary under the circumstances, including without limitation, the administration and maintenance of anesthesia and the performance of pathology and radiology services. By signing below, I give my consent for the pathologist to use his/her discretion in the disposal or use of any member, organ or other tissue removed from my person during the surgery or procedure stated above, except for the following conditions:_____
_____.

4. I understand that the persons performing surgery, anesthesia, radiology and pathology services during the surgery, care, treatment, special diagnostic or therapeutic procedures set forth above are not the employees, agents or servants of Huntington Memorial Hospital, but are independent contractors and therefore are the employees, agents and servants of myself.

5. **MY SIGNATURE BELOW INDICATES THAT ALL OF THE FOLLOWING ARE TRUE:**

- **I have thoroughly read and I fully understand all the information contained in this form,**
- **I have had the nature of the treatment, care, surgery or procedure, its significant complications, risks and benefits, side-effects, potential recuperative problems, likelihood of achieving goals, possible alternatives, the significant complications & risks associated with these alternatives and the possible consequences of no treatment at all fully explained to me by my physician(s).**
- **I have had the opportunity to ask my physician(s) any questions,**
- **I have received all the information I desire concerning the surgery or procedure and,**
- **I know I have the right to refuse to consent to the surgery, care, treatment, special diagnostic or therapeutic procedures and I have knowingly waived that right, and**
- **I authorize and consent to the performance of the surgery, care, treatment, special diagnostic or therapeutic procedures.**

Patient Signature: _____

Date: _____ **Time:** _____ **am/pm**

Witness: (Print) _____ (Signature) _____ **Date/Time:** _____

Language Line Operator #: _____

Intrepreter: (Print) _____ (Signature) _____ **Language:** _____

*** If patient is a minor or unable to sign, please answer the following:

Patient is a minor: **Yes** **No** Patient is unable to sign: **Yes** **No**

Explain Relationship: _____

Name of signator: (Print) _____ (Signature) _____ **Date/Time:** _____

Witness: (Print) _____ (Signature) _____ **Date/Time:** _____

Language Line Operator #: _____

Intrepreter: (Print) _____ (Signature) _____ Language: _____

TELEPHONE CONSENT

I have spoken with _____, the _____ of the above named patient, and have received permission from this person to proceed with (procedure) as described in the telephone conversation, and to administer whatever surgery, care, treatment, special diagnostic or therapeutic procedure is necessary.

Physician: (Print) _____ (Signature) _____ **Date:** _____ **Time:** _____

Witness: (Print) _____ (Signature) _____ **Date:** _____ **Time:** _____

Witness: (Print) _____ (Signature) _____ **Date:** _____ **Time:** _____

Language Line Operator #: _____

Intrepreter: (Print) _____ (Signature) _____ Language: _____

PHYSICIAN CERTIFICATE OF EMERGENCY

This is to certify that the delay necessary to obtain complete consent for treatment would endanger this patient's life or chance for recovery. **I believe the emergency operation is necessary.**

Physician: (Print) _____ (Signature) _____ **Date:** _____ **Time:** _____

Witness: (Print) _____ (Signature) _____ **Date:** _____ **Time:** _____