



AUTHORIZATION AND CONSENT FOR SURGERY

I, _____ (**print patient name**), authorize **Dr. Alexander Digenis**, with his assistant(s) of choice, to perform the following procedures/surgeries upon:

Name of Procedure/Surgery:

The nature and effect of the Procedure/Surgery to be performed, the risks involved, and the alternate methods of treatment have been explained to me. Dr. Alexander Digenis has explained to me the most likely complications or problems that might occur in this procedure/surgery and during the healing period, and I understand them. _____ (**please initial**)

I consent to the photographs of the area involved to be made part of the medical records and consent to their use in teaching purposes or scientific articles or medical legal testimony, provided my identity is not revealed. _____ (**please initial**)

I hereby consent to authorizing and directing Dr. Alexander Digenis with his assistants to provide such additional services as they may deem reasonable and necessary including, but not limited to, the administration of any anesthetic agent and other medication, or the services of the X-ray department and laboratories. _____ (**please initial**)

I know that the practice of medicine and surgery is not an exact science, and I am advised that although good results are expected, there cannot be any guarantee, nor warranty, expressed or implied, by anyone, as to the results that may be obtained. I have read this paragraph and I understand it.
_____ (**please initial**)

Patient Signature: _____ **Date:** _____

Patient Name (printed): _____

Witness: _____