The Surgery Center of Alta Bates Summit Medical Center
3875 Telegraph Avenue ▪ Oakland, CA 94609

AUTHORIZATION FOR SURGERY ANESTHESIA, DIAGNOSIS OR THERAPEUTIC PROCEDURES

1. Your doctor explained to your satisfaction, the operation, procedure, or therapy (including any necessary anesthesia) and its risks, benefits, side effects, available alternatives, if any, and when applicable, mandatory disease reporting to local or state health departments or the Centers of Disease Control and Prevention for diseases such as HIV, tuberculosis, viral meningitis or any other reportable diseases. This form is not a substitute for that explanation.

2. Anesthesia risks range from minor complications like nausea through serious long term complications. Serious anesthetic complications are very rare; I will have the opportunity to discuss these risks with my anesthesiologist. For some procedures, the Surgeon or Pain Physician will provide intravenous sedation ("Moderate Sedation"). If this is the planned type of anesthesia for my procedure I understand that I will have an opportunity to discuss with my Surgeon or Pain Physician the risks and ask any questions about Moderate Sedation prior to receiving any sedation.

3. My consent is given with the understanding that any operation or procedure involves risks and hazards. All operations and procedures 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 result or cure. You have the right to be informed of:
   - The nature of the operation or procedure, including other care, treatment or medications;
   - Potential benefits, risks or side effects of the operation or procedure, including potential problems that might occur with the anesthesia to be used and during recuperation;
   - The likelihood of achieving treatment goals;
   - Reasonable alternatives and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment; and
   - Any independent medical research or significant economic interests your doctor may have related to the performance of the proposed operation or procedure.

   Except in cases of emergency, operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to give or refuse consent to any proposed operation or procedure at any time prior to its performance.

4. In the event of an accidental exposure of my blood or bodily fluids to a physician, contractor or employee of the facility, I consent to testing for HIV and Hepatitis.

5. Your signature below will authorize:
   a. Your doctor (and any needed assistants) to perform the above-named operation or procedure and to provide such additional services as may be deemed medically reasonable and necessary, including, but not limited to:
      - The administration and maintenance of anesthesia.
      - Pathology and radiology services

   b. The pathology services to use its discretion in the disposal of any excised or removed tissue.
   c. I hereby consent to be photographed while receiving treatment at the Surgery Center.
      - I understand that the images from such photography may be used for my treatment or medical education as my treating physician deems necessary. The term "photograph" as used herein includes video, still photography, or radiography, in digital or any other format, and any other means of recording or reproducing images.

MRN:	ACCT:
DOS:	SEX:
DOB:	AGE:
ATTENDING:	

6. Your signature on this form indicates that:
   - You have read and understand the information provided in this form;
   - Your doctor has adequately explained to you the operation or procedure and the anesthesia set forth above, along with the risks, benefits, and alternatives, and the other information described above in this form;
   - You have had a chance to ask your doctors questions;
   - You have received all of the information you desire concerning the operation or procedure and the anesthesia; and
   - You authorize and consent to the performance of the operation or procedure and the anesthesia.

7. **Transportation Arrangements:**
   - I understand that if my procedure requires only a local anesthetic, I may drive home.
   - All other forms of anesthesia require that I have made prior arrangements for the presence of a responsible adult at my time of discharge to drive me home.

8. Your Doctor has recommended the following operation to be performed:

Date/Time	Patient Signature
Date/Time	Witness Signature
Date/Time	Circulator Signature
Date/Time	Surgeon or Physician Assistant Signature

I have accurately and completely read the foregoing document to _____ (insert patient's or legal representative's name) in _____ (identify language), the patient's or legal representative's primary language. He/She understood all of the terms and conditions and acknowledged (his/her) agreement thereto by signing the document in my presence.

Interpreter's ID#	Interpreter if Applicable

(If patient is a minor or unable to sign, complete the following.)

The Patient, _____, is a minor, or is unable to sign because: _____

Relationship: ☐ Parent ☐ Guardian ☐ Legal Custodian

Parent/Guardian/Legal Custodian Signature	Witness Signature

MRN: ACCT:
DOS: SEX:
DOB: AGE:
ATTENDING: