

2355 North Wyatt Drive, Suite 111 | Tucson, Arizona 85712 | 520-323-7100

**Patient Informed Consent**

1. I, , hereby authorize and direct Dr. Peter P. Kay, M.D. (herein called “Dr. Kay”), his associates and assistants of his choosing to perform the following operation (and/or procedure) on myself as we have agreed upon:

1. I further authorize Dr. Kay to do any procedure that his judgment may dictate to be advisable for my well-being. It is understood that he will give his best professional care toward the accomplishment of the desired results.
2. The nature of the operation has been explained to me and the possible complications specified for this particular operative procedure. This authorization is given with the understanding that any operation or procedure involves some risks and hazards. Some of these risks include, but are not limited to, bleeding, scarring, infection, nerve injury, blood clots, and allergic reactions.
3. I am advised that though good results are expected, complications cannot be anticipated, and that therefore there can be no guarantee either expressed or implied as to the results of the surgery or care.
4. The administration of anesthesia also involves serious risks, most important are risk of reaction to medications. I consent to the use of such anesthetics as may be considered necessary be the person responsible for these services.
5. I hereby authorize and direct Dr. Kay and his associates or assistants to provide (or arrange) such additional services as they may deem reasonable and necessary including the services of a hospital and/or the departments of Radiology, Pathology, Laboratories, and I hereby consent thereto.
6. I also consent to the taking of photographs of me to be used for medical records, scientific, or educational purposes.
7. I have read and fully understand this consent form and feel that all my questions have been answered to my satisfaction. I have no further questions.

**IF YOU HAVE ANY QUESTIONS ABOUT THIS OPERATION OR PROCEDURE, OR THE RISKS RELATED TO THE OPERATION OR PROCEDURE, ASK DR. KAY *BEFORE* SIGNING THIS FORM.**

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. PHYSICIAN DECLARATION: I have explained the operation or procedure, and the contents of this document to the patient and have answered all the patient’s questions. To the best of my knowledge, the patient has been adequately informed. The patient has consented to the above named operation or procedure.

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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