PRISMA HEALTH®

Prisma Health Medical Group
Consent for Operation, Diagnostic and/or Treatment Procedure

Patient Name	DOB	MRN

I hereby consent to and authorize Prisma Health Medical Group (Medical Group) and the designated physician, Dr. _____ and/or such assistants as may be selected by the physician to perform or have performed the following procedure(s) on:

Patient Name: _____

List Procedure(s): _____

_____

The Physician has explained the following:

1. The nature and purposes of the proposed procedure(s)
2. Risk, benefits and consequences of the procedure(s)
3. Risk and prognosis if no treatment is rendered
4. The probability that the proposed procedure(s) will be successful
5. Alternative methods of treatment (if any) and their associated risks and benefits
6. Other practitioners may be assisting him/her in performing this procedure on me, including (but not limited to) _____.
   (They may perform tasks such as opening and closing the incision, dissection tissue, removing tissue, altering tissue, harvesting grafts and/or implanting devices.)

[ ] I have been given an information sheet on the above-mentioned procedure (if applicable).

I understand that all surgery involves general risks such as severe loss of blood, infection and severe life threatening situations. No guarantees have been made to me that this operation will improve my condition. The Physician has explained to me that sometimes during surgery it is determined that additional surgery is needed immediately. If I need such additional surgery during my operation, I permit the Physician to proceed.

Informed Consent for Disposal of Tissues and/or Blood: I consent to the disposal by hospital authorities of any tissues, blood, body parts/limbs, prostheses, or foreign objects that may be removed during the course of the procedure.

Informed consent for Retention and Use of Tissues and/or Blood: I consent to hospital authorities, at their discretion, saving for research or for educational purposes the tissue or blood normally discarded. I understand that saved tissues and/or blood will not identify me in any way.

Informed consent for Observation: I consent to allowing medical personnel and trainees to observe my operation or procedure for the purpose of advancing medical education, subject to the consent and approval of my Physician and only under such conditions and at such times as may be approved by my Physician.

Informed consent for Presence of Vendors: I consent to allowing technical representatives and/or vendors requested by my Physician to be present during my procedure to provide support services including those involving their product. These technical representatives and vendors are necessary for their knowledge of medical products and/or equipment.

Informed Consent for Photography: I consent to allowing personnel approved by the Medical Group and/or my Physician to photograph, video, record and/or produce and other image of some or all of my procedure (hereinafter referred to collectively as "photographs"). I understand the photographs may be used for my treatment and may become part of my medical record. I further understand such photographs may be used for educational purposes.

If you do not give permission for any of the above, strike through the sentence(s) and initial to the left of the paragraph.

Patient's Signature or Legally Qualified Representative	Patient/Guardian Print Name	Date/Time
Relation to Patient		Date/Time
Prisma Health Medical Group Representative		Date/Time