ENCOMPASS
MEDICAL GROUP

# CONSENT FOR PROCEDURE OR TREATMENT

Date: _____ Time: _____

I hereby authorize (**Physician name**) _____ and whomever he / she may designate as his / her assistants to perform upon (patient name or "Myself") (**MYSELF**) at Encompass Medical Group the following procedure: _____.

Y ___ N___ PATIENT REPORT ALLERGIES TO BIOPSY SUPPLIES (LATEX, BETADINE ,LIDOCAINE ,EPII)

Understanding the Procedure and Risks
The nature and purpose of the procedure, its probable consequences, and possible complications have been explained to me, and I understand them. I acknowledge that no guarantee or assurance has been made about the results. Risks include bleeding and infection.

Authorization for Additional Procedures
I understand that unforeseen conditions discovered during the procedure may require an extension of the planned procedure or a different procedure. I authorize and request the above-named physician or their designated consultant to perform procedures that, in the physician's professional judgment, are necessary and desirable. This authorization extends to treatment of all conditions requiring treatment that were unknown to the physician when the procedure began.

Consent for Tissue Examination and Handling
I also consent to the pathological examination and retention or disposal of any tissue or parts removed during the procedure.

**I certify that I have fully read and understand the above consent to procedure or treatment, that the explanations therein referred to were made, and that all my questions regarding this procedure have been completely answered.**

**WITNESS TO SIGNATURES:**

_____ _____

(Signature of Technologist) (Signature of Patient or authorized individual)

_____ _____

(Printed name/technologist) (Printed name/patient or authorized individual)

_____ _____

(Signature of radiologist) (Printed name of radiologist)