Print Form

Texas Health
Center for Diagnostics & Surgery
PLANO

PATIENT LABEL

DISCLOSURE AND CONSENT MEDICAL AND SURGICAL PROCEDURES

This form fulfills the disclosure requirements as set forth by the Texas Medical Panel

PATIENT_____

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. The disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed and that you may give or withhold your consent to the procedure.

I (We) voluntarily request Dr._____as my physician, and such associates, technical assistants and other healthcare providers as they may deem necessary, to treat my condition which has been explained to me by my physician as:

_____

And I hereby release my physician and Texas Health Center for Diagnostics & Surgery, and any other participating health care providers from any and all liability for any adverse effects that may result from these procedures.

I (We) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (We) voluntarily consent and authorize these procedures:

_____

_____

I (We) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (We) authorize my physician, and such associates, technical assistants and other healthcare providers to perform such other procedures which are advisable in their professional judgment.

I (We) understand that no warranty or guarantee has been made to me as to result or cure. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (We) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (We) also realize that the following risks and hazards may occur in connection with this particular procedure:

_____
Initial

_____

_____ **I (We) (do) consent to the use of blood and blood products as deemed necessary, I (We) realize that the following risks and hazards may**
Initial **occur in connection with this particular procedure: Fever, transfusion reaction which may include kidney failure or anemia, heart failure, hepatitis, A.I.D.S. (acquired immune deficiency syndrome), other infections.**

_____ **I (We) (do not) consent to the use of blood and blood products during this hospitalization. In refusing consent, I (We) realize that if an**
Initial **Unforeseen bleeding complications develops, my doctor's ability to treat such a condition could be substantially compromised. Moreover The withholding of blood products under circumstances could result in death.**

I (We) authorize the use of X-ray and any radiological procedure in conjunction with the above procedure.
I (We) authorize the hospital pathologist to use his/her discretion in the disposal of any severed tissue or member.
I (We) consent to the use of video equipment, photography, and/or the presence of a qualified observer during the procedure.
I (We) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I (We believe that I (We) have sufficient information to give this informed consent.
I (We certify this form has been fully explained to me, that I (We) have read it or have had it read to me, that the blank spaces have been filled in, that I (We) understand its contents, and that a copy of this form has been made available to me.

A.M.
_____**DATE:**_____**TIME:**_____ **P.M.**
SIGNATURE OF PATIENT/OTHER LEGALLY RESPONSIBLE PERSON

_____
SIGNATURE OF WITNESS