

# Medical Procedure Consent Form

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Procedure: \_\_\_\_\_

Physician: \_\_\_\_\_

## Purpose of the Procedure

The purpose of this procedure is to: \_\_\_\_\_.

## Risks and Benefits

Risks associated with this procedure include: \_\_\_\_\_.

Benefits of this procedure include: \_\_\_\_\_.

## Consent

I, the undersigned, hereby consent to the performance of the aforementioned procedure. I understand the risks and benefits involved, and I have had the opportunity to ask questions regarding the procedure. I acknowledge that no guarantee has been made regarding the outcome.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_