Surgical Procedure Authorization Agreement

Date: _____

Patient Name: _____

Patient ID: _____

Procedure: _____

Surgeon: _____

Facility: _____

Authorization

I, the undersigned patient or legal guardian, hereby authorize Dr. _____ to perform the surgical procedure described above.

Understanding of Procedure

I acknowledge that I have been informed about the nature of the procedure, the inherent risks, and the potential benefits.

Consent

I consent to the surgical procedure as outlined and understand that I have the right to ask questions before signing.

Signature

Patient/Guardian Signature: _____

Date: _____

Witness

Witness Signature: _____

Date: _____