



## PROCEDURE CONSENT AUTHORIZATION

To: \_\_\_\_\_  
(Name of patient)

1. Your physician is Dr. Red M. Alinsod
2. South Coast Urogynecology maintains personnel and facilities to assist your physicians and surgeons in the performance of various surgical, special diagnostic or therapeutic procedures. These procedures may all involve risks of unsuccessful results, complications, injury or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have the right to be informed of such risks as well as the nature of the procedure, the expected benefits or effects of such procedure, and the available alternative methods of treatment and their risks and benefits. You also have the right to be informed whether your physician has any independent medical research or economic interests related to the performance of the proposed procedure. Except in the cases of emergency, procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent or to refuse any proposed procedure at any time prior to its performance.
3. Your physician has recommended the following procedure(s):  
\_\_\_\_\_  
\_\_\_\_\_

Upon your authorization and consent, this procedure will be performed on you. The procedure will be performed by the physician named above and may involve associates or assistants including other physicians, nurses, medical assistants, or office personnel.

4. To make sure that you fully understand the procedure, your physician will fully explain the procedure to you before you decide whether or not to give consent. If you have any questions, you are encouraged and expected to ask them.
5. Your signature on this form indicates that (1) you have read and understood the information provided in this form, (2) the procedure set forth above has been adequately explained to you by your physician, (3) you have had a chance to ask questions, (4) you have received all of the information you desire concerning the procedure, and (5) you authorized and consent to the performance of the procedure.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_