Request for Medical/Surgical Procedure Release

(Informed Consent)

I, _____, do hereby consent and authorize the following described medical procedures upon me by or under the direction of Hugh Chatham Medical Group providers, assistants and associates:

Procedure:

_____ Endometrial Biposy _____ Colposcopy _____ IUD Insertion

_____ Other: _____

I acknowledge that the following information has been provided to me:

- I am aware that possible complications of this procedure could include but are not limited to:

Endometrial Biopsy - risk of infection, bleeding, pain, perforation, need of repair or need of repeat procedure

Colposcopy - risk of infection, bleeding, pain, need for repeat procedure, post-colposcopic vaginal bleeding, or cervicitis/endometritis

IUD Insertion - infection, bleeding, perforation, risk of Ectopic pregnancy, displacement, need for removal, irregular menses, failure resulting in pregnancy, or pain

And/or:_____

- I request the administration of such anesthetics as may be considered necessary or advisable by the physician and/or the nurse practitioner.

- The nature and the purpose of the procedure, possible alternative methods or treatment and the risks involved have been fully discussed with me by my provider. I understand that there can be no guarantee of outcome with any medical procedure and acknowledge that no guarantee has been made to me with regard to this procedure/procedures.

- I further agree that photographs and a narrative of my case may be utilized for medical education or science, including publication in professional journals and medical books. However, any publication of these photographs or narrative will exclude my name so as to protect my identity.

- I further consent to the disposal of tissue or parts removed at the time of the operation.

- I further acknowledge that I have been given full opportunity to discuss the matter contained herein with my provider and assistants, or replacements and that I understand the information provided.

_____ _____

Signature of Patient Date Signature of Witness Date

_____

Signature of Parent/Legal Guardian Date

I have personally explained the above information to the patient or the patient's authorized representative.

_____

Provider Name

_____

Provider Signature Date

Patient's Date of Birth: _____/_____/_____

Patient's Chart Number: _____

Patient's ID _____

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Hugh Chatham Medical Group
an affiliate of Hugh Chatham Memorial Hospital