

# Consent for Anesthesia Administration

**Patient Name:**

**Date of Birth:**

**Procedure:**

I hereby authorize Dr.  and the medical staff to administer anesthesia as required for the above procedure. I confirm that the risks, benefits, and alternatives have been explained to me and that I have had the opportunity to ask questions.

☐ I understand and agree to the terms above.

**Patient/Guardian Signature:**

**Date:**