

Consent to Anesthesia and Surgery

I hereby authorize Dr. and his/her associates to perform the following surgical procedure:

I understand that anesthesia will be used as described by the doctor or anesthesiologist. The risks, benefits, and alternatives to anesthesia and surgery have been explained to me. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.

Patient Information

Name:

Date of Birth:

Signatures

Patient Signature:

Date:

Witness Signature:

Date: