

UROLOGY ASSOCIATES, P.C.

Day-Op Center

833 Northern Blvd
Great Neck NY 11021

Consent for Operative/Invasive/Diagnostic Procedures Requiring Anesthesia or Sedation/Analgesia

1. **Permission:** I hereby authorize Dr. _____ and his/her associates or assistants who are partners at Urology Associates to perform the following procedure(s): _____

_____ including such photographing, videotaping, televising or other methods of visually recording the procedure(s) for the advancement of medical knowledge and/or education, with the understanding that my (the) patient's identity will remain anonymous.

Laterality level confirmed by Anesthesiologist

Laterality level confirmed by Surgeon

2. Explanation of procedure(s), risks, benefits and alternatives.

Dr. _____ has fully explained to me the nature and purpose of the procedure(s) and also informed me of expected benefits and complications (from known, causes), attendant discomforts and the risks that may arise as well as possible alternative methods of diagnosis and/or treatment to the proposed procedure(s), including no treatment. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.

3. **Anesthesia.** I further consent to the administration of such anesthetics, sedatives, or analgesics as may be considered necessary.

4. **Specimens:** Any organ or tissues surgically removed may be examined and retained by Urology Associates, PC for medical scientific or educational purposes and such tissues or parts may be disposed of in accordance with customary practices and applicable State Laws and regulations.

5. **Understanding this form:** I confirm that I have read this form, fully understand its contents and that all blank spaces have been completed prior to my signing. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedure(s) described above.

Patient/Agent/Relative/Guardian Signature Date Print Name Relationship

Interpreter<if required (Signature) Date Print Name

Witness to signature Date Print Name

Physician's Certification. I hereby certify that I have explained the nature, purpose, benefits, complications from, risks, alternatives to (including no treatment and attendant risks), the proposed procedure/operation, have offered to answer any questions. I believe that the patient/agent/relative/guardian fully understands what I have explained and answered. I further certify that the "Permission" section of this form accurately certifies the proposed procedure, if applicable.

Physician's signature Date