SUMMIT
SURGERY CENTER
OF SANTA BARBARA

Authorization And Consent

To: (Name of Patient)_____

Operation or Procedure: _____

The Physician performing your procedure is _____ MD.

Summit Surgery Center maintains personnel and facilities to assist the patient's physicians and surgeons in their performance of various surgical operations and other special diagnostic or therapeutic procedures. These operations and procedures may all involve risks or unsuccessful results, complications, injury or even death, from 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 operation or procedure: methods of treatment and their risks, alternatives, and benefits. Except in cases of emergency or medical necessity, operations or procedures are not performed until you have had the opportunity to receive this information and given your consent. You have the right to consent or to refuse any proposed operation or procedure any time prior to its performance. _____ (initial)

The patient's physician and surgeon have recommended the operations or procedures set forth above. Together with any different or further procedures, which may be indicated by an emergency or which your physician may consider medically necessary or advisable in the course of the procedure, these will be performed by the physician or surgeon named above, upon your authorization and consent.

In the event of any emergency causing his or her inability to complete the procedure, the physician or surgeon may assign designated responsibilities to a qualified substitute physician or surgeon of Summit Surgery Center.

The persons in attendance for the purpose of performing specialized medical services such as anesthesia, radiology, or pathology are not agents, servants, or employees of Summit Surgery Center, but are independent contractors. All of your physicians are acting as your agents. Other individuals providing technical support may be present at your physician's or surgeon's request. You/the patient have the right to request that individuals providing technical support not be present during the operation or procedure.

Anesthesia involves the use of medication. Different individuals react differently to the same medication, and the state of their physical health influences the action of medicine. While all possible precautions will be taken, unforeseen reactions may occur. By signing this agreement you verify your understanding and acceptance of the fact that certain hazards and risks are inherent in any anesthetic procedure. You further verify your understanding that post-anesthetic nausea, vomiting, headache, phlebitis, sore throat with laryngeal and tracheal swelling, dental injuries, more serious heart and lung abnormalities or nerve and/or muscle disorders as well as other problems may occur, and any anesthetic procedure (including, but not limited to general, local, conscious sedation, monitored anesthesia care, spinal, and epidural) may cause complications, including death.

The pathologist is hereby authorized to use his or her discretion in disposing of any specimen, organ, or other tissue removed from you/the patient's person during the operation(s) or procedure(s) set forth above.

The Summit Surgery Center physician or surgeon is hereby authorized to photograph or videotape you/the patient for medical purposes, while under the care of the institution.

Your signature below constitutes your acknowledgement (1) that you have read and agree to the foregoing; (2) that the operation or procedure set forth above has been adequately explained to you by the above named physician or surgeon and that you have received all of the information you desire concerning such operation or procedure; (3) that you authorize and consent to the performance of the operation or procedure as well as the administration of anesthesia; and (4) you acknowledge the receipt of a copy of this authorization.

_____

Signature: (Patient/ Parent/ Conservator/ Guarantor) Date Time

_____ _____

Witness (Other than patient's signature) Relationship to Patient

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