

DRS. GEHRIS, JORDAN, DAY & ASSOCIATES, LLC

Head and Neck Surgery . Ear, Nose and Throat Surgery . Facial Plastic & Reconstructive Surgery

Otolaryngology – Head and Neck Surgery
C. W. Gehris, Jr., M.D., FACS
T. E. Jordan, M.D., FACS
K.V. Day, M.D.
C.M. Lawson, M.D.
L.R. Proctor, M.D.
T.M. Clark, C.R.N.P.

General Plastic & Reconstructive Surgery
T.E. Jordan, M.D., FASC
Audiology
D.D. Allen, M.S., FAAA
S.N. Domzalski, M.S., CCC-A, FAAA
A.C. Waite, M.S., CCC-A, FAAA
K. Garson, AuD, CFY

**AUTHORIZATION AND INFORMED CONSENT
FOR SURGERY/SPECIAL PROCEDURES**

TO THE PATIENT: Please Read Carefully

I authorize the performance upon _____
(myself or name of patient and relationship)
the following special procedure and/or operations: _____

to be performed by Doctor _____ and/or his associates and such other assistants as may be required by him/her, and the performance of additional procedures or operations as are considered necessary on the basis of the findings during the course of such designated treatment or operation. Alternate forms or treatment and the advantages and possible complications and risks of this procedure have been explained to me by the physician listed above or by Doctor _____.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examination.

If appropriate, local anesthesia has been explained by my surgeon.

I consent to the examination and/or disposal of the tissues or parts which may be removed from my body and hereby authorize to retain, preserve, photograph, and use for scientific or teaching purposes any specimens or tissues that may be taken from my body.

Did you read this form? Yes No, Did you understand this form? Yes No, Do you have any questions? Yes No

I certify that I have read, understand, and have discussed this Authorization and Informed Consent for Surgery/Special Procedures with my surgeon and/or his associates and all of my questions regarding the proposed operation/special procedure have been answered.

(Patient, Nearest Relative, Legal Guardian) (Witness)

Date: _____ Time: _____ a.m./p.m. _____ Relationship if not signed by patient

This is to certify that I have explained to _____ the proposed surgery and/or special procedure, the alternatives, and the possible complications and risks. _____ was offered the opportunity to ask additional questions. _____ appeared to understand the proposed procedure and alternatives.

Date Signature of Physician

This form cannot be signed by patient because:
 Patient is a minor Patient is unable to sign due to: _____