CONSENT

- I voluntarily give my permission to the health care providers of South Plains Surgery Center and other health care assistants as deemed necessary to provide medical services to me. I understand that I should communicate any special considerations related to a cultural, spiritual, or ethical belief that may affect my plan of care.

- I ___(do) or ___ (do not) consent to the use of blood and blood products as deemed necessary. if declining; I understand that the refusal to receive blood products may be life threatening. The risks associated with receiving blood or blood products are: 1. Fever. 2. Transfusion reaction, which may include kidney failure or anemia. 3. Heart failure. 4. Hepatitis. 5. HIV (Human Immuno-Deficiency Virus) and/or AIDS (Acquired Immune Deficiency Syndrome) 6. Other infections.

- I authorize the pathologist at his discretion, to maintain or discard any bodily specimen.

- I understand that if I am discharged the same day as my surgery, I should not operate a motor vehicle or machinery, or potentially dangerous appliances, drink alcoholic beverages or make critical decisions for 24 hours, I understand that I must be accompanied by a responsible adult when I am discharged.

- I understand that my physician may order a blood test drawn from me for (including but not limited to) HIV (AIDS) and Hepatitis antibodies. I consent to that withdrawal only if an employee or physician has had an accidental exposure to my bodily fluids. I understand that I can obtain the results of these tests from my physician who can explain them. I authorize release of data necessary to process the testing and the insurance claim and I understand there will be no cost to me for this test.

- PHOTOGRAPHS/VIDEO TAPES: I give my consent for any photographing or videotaping deemed necessary by my surgeon for medical, scientific or educational purposes provided my identity is not revealed. I understand these photographs and/or video tapes are the property of my surgeon.

- I understand that my name, address, telephone number and social security number could be provided to the manufacturer if part of my treatment includes implanting a medical device that falls under the tracking requirements of the Food & Drug Administration.

- I do not consent to the admittance of a:

  □ Resident assistant □ Resident observer □ Student observer □ Private Surgical Technician
  □ Private Registered Nurse □ Sales representative for the purpose of observation and consultation

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.

DATE: _____ TIME: _____ A.M./P.M.

_____
Signature of Patient/Relative or Guardian*

SPSC-1124

Relationship if signed by person other than patient _____

_____
WITNESS/INTERPRETER: