Hudson Yards Surgery Center
450 West 31st Street 2S New York, NY 10001
PATIENT'S NAME:_____**Date of Birth :** _____

CONSENT FOR OPERATION, ANESTHESIA, SPECIAL TREATMENTS OR PROCEDURES

I hereby authorize (Physician Name)_____, M.D. and /or such associates and assistants as may be designated by (him) (her) to treat the condition or conditions in connection with my (the above patient's) hospitalization in the Hudson Yards Surgery Center . I authorize them to perform the operation and/or diagnostic procedure(s) known as:

_____

_____

The operation and/or diagnostic procedure(s) (has) (have) been explained to me in laymen's terms by Dr. _____ and I understand (its) (their) nature.

I have been made aware of certain risks, hazards, complications, and consequences that are associated with the above operation, anesthesia, treatment(s) and procedure(s), as well as possible alternative modes of treatment. I acknowledge that no guarantees have been made to me concerning the results of the procedure.

It has been explained to me that during the course of an operation, unforeseen conditions may be revealed that necessitates an extension of the original procedure(s) or different procedure(s) than those set forth in Paragraph 1. I therefore authorize and request that the above-named surgeon, (his) (her) associates and/or assistants perform such surgical procedures as are necessary and desirable in the exercise of their professional judgement. The authority granted under this paragraph shall extend to treating all conditions that require treatment and are not known to the physician performing the authorized operation at the time the operation commenced.

I have also been informed that there are risks including but not limited to severe loss of blood, infection and/or cardiac arrest that are attendant to the performance of any surgical procedure. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of the above operation, treatment(s) or procedure(s).

I further consent to disposal by Hudson Yards Surgery Center, in accordance with its accustomed practice, of any tissue or parts, that may be removed.

I also consent to the admittance of observers to the Operating Room, and to photographing, televising or videotaping of the operation or procedure to be performed, including appropriate portions of my (the above patient's) body, for the purpose of advancing medical education and for other medical or scientific purposes provided my (the above patient's) identity is not revealed by either the pictures or the descriptive texts accompanying them.

I consent, authorize, and request the administration and management of such anesthesia as is deemed suitable by the anesthesiologist assigned to my procedure. It is my understanding that the anesthesiologist will have full charge of the administration and management of the anesthesia and any other necessary, associated procedures for anesthesia.

I acknowledge that the foregoing information does not cover all of the specific information that has been provided by the above-named practitioner. But the information set forth above was provided tot me and I have had full opportunity to ask questions and to have received additional information.

I acknowledge and agree that I have had the opportunity to ask questions and that all my questions have been answered.

_____	_____	_____	_____	_____
Signature	Print Name	Date	Time	Relationship
_____	_____	_____	_____	_____
Witness Signature	Print Name	Date	Time	Relationship

PHYSICIAN'S STATEMENT OF INFORMED CONSENT

I hereby certify that I have explained the nature, purpose, benefits, risk of, and alternatives to the proposed procedures/operations and/or anesthesia, and have fully offered to answer any questions. I believe that the patient (relative/guardian) fully understands what I have explained and answered.

_____	_____	_____	_____
Physician's Signature	Print Name	Date	Time