



**STATEMENT OF INFORMED CONSENT FOR MEDICAL PROCEDURE**

My physician has recommended that the procedure noted below be performed. The risks of the procedure have been explained to me and are also noted on this form. Any questions I have regarding the medical procedure, why it is necessary, its benefits and risks have been answered to my satisfaction. Therefore I give my informed consent to the performance of the procedure by signing this statement of informed consent.

Procedure to be performed: \_\_\_\_\_

Potential significant risk(s): \_\_\_\_\_

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the physician or Summit Medical Group. I have also previously signed a Consent for Medical Treatment form for Summit Medical Group and that form is incorporated by reference into this form as of the date of my signature.

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

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Patient's Name (Printed)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Patient, \_\_\_\_\_, is a minor, or is unable to sign above because: \_\_\_\_\_.  
(Name Printed)

\_\_\_\_\_  
Person Giving Consent

\_\_\_\_\_  
Relation to Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date