

HIGH PLAINS SURGERY CENTER

- I voluntarily give my permission to the health care providers of High Plains Surgery Center and other health care assistants as deemed necessary to provide medical services to me. I understand that I am responsible for communicating to High Plains Surgery Center my need for 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 include the following: (1) Fever (2) Transfusion reaction, which may include kidney failure or anemia (3) Heart failure (4) Hepatitis (5) HIV (Human Immunodeficiency 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 on 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 body fluids. I understand that I can obtain the results of these tests from my physician who can explain them. I authorize the 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 video taping 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 the implantation of a medical device that falls under the tracking requirements of the Food & Drug Administration.
- I do not consent to the admittance to the operating room of a:
___ Resident assistant ___ Resident observer ___ Student observer
___ 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 or Relative or Guardian*

*Relationship if signed by person other than patient _____

Witness/Interpreter: High Plains Surgery Center
3610 22nd Street
Lubbock, Texas 79410