BOSTONIVF

AUTHORIZATION AND CONSENT FOR PROCEDURE

This form is a consent for a procedure. It states that you have discussed the matter with your doctor, understand the risks, and wish to have the procedure performed. You should read the consent carefully before signing. You should not sign this form if you have not discussed the matter with your doctor.

This is to acknowledge that I agree to the diagnostic procedure known as:

OFFICE DIAGNOSTIC HYSTEROSCOPY

Name of Procedure

The reasons why it is considered necessary, its advantages and possible complications, as well as the possible additional or alternative modes of treatment have been explained by:

(Name or Names of Physicians and Surgeons)_____M.D.

_____ M.D.

In light of such information, the undersigned requests and authorizes the above physician(s) and assistants of his/her/their choice to perform the procedure(s) described above, or such additional procedures and extensions, not anticipated, as may be considered by them to be therapeutically necessary or desirable on the basis of findings in the course of the procedure.

The general nature of the procedure and its normal risk and consequences have been described to me.

THERE IS A RISK OF INFECTION, BLEEDING, OR UTERINE PERFORATION.

I acknowledge that no guarantee or assurance has been made to as the results may be obtained.

All tissues surgically removed, if any, are to be examined and disposed of by a designated laboratory in accordance with its accustomed practice.

ANY DELETIONS, ALTERATIONS, OR ADDITIONS TO THE ABOVE LANGUAGE MUST BE MADE BEFORE THE SIGNATURE.

DATE:_____ SIGNED: _____

(Signature of Patient)

_____

(Patient's Name – Please Print)

_____

(Witness)