CONSENT TO OPERATION,
ADMINISTRATION OF ANESTHETICS
AND RENDERING OF OTHER MEDICAL SERVICE

1. I AUTHORIZE AND DIRECT DR. G. DASSA M.D., with the Associates and Assistants of his choice to perform upon me (the patient) the following operation(s) and or procedure(s):

   and to administer such routine diagnostic tests and procedures, including, but not limited to the administration and/or injection of pharmaceutical products and medications and the drawing of blood as my physician or such associates and assistants deem necessary or advisable in my (the patient's) care, including such photographing, videotaping, or other observation of the operation(s)/procedure(s) as may be purposeful for the advance of medical knowledge and/or education with the understanding that my (the patient's) identify will remain anonymous.
   If any unforeseen condition arises in the course of the operation or in the post-operative period, calling in their judgment for other operations, diagnostic or therapeutic procedures in addition to or different from those now contemplated, including the transfer to a hospital. I further request and authorize them to do whatever is deemed advisable for my health and well being.

2. The nature of and purpose of the operation, benefits and alternate means of therapy have been explained to me. I acknowledge that no guarantee or assurance has been made as to results or cure. Additionally, I have been informed that there are risks, regards, complications, and consequences that are attendant to the performance of any operation on procedure, including pain discomfort, injection, hemorrhage.

3. I consent to the administration of anesthesia and supportive measures by or under the direction of the Department of Anesthesiology and to the use of such anesthetics such as the members of that Department deem advisable. I also understand that there are risks to life and health associated with anesthesia and such risks have been explained to me.

4. I hereby authorize the Surgicare to retain, preserve and use for scientific or teaching purposes, or dispose of at their convenience, any specimens or tissues taken from my body.

5. I authorize and grant permission to Eye Surgery Center of Westchester to obtain any medical records of information, prior or subsequent, pertaining to this procedure that may be necessary.

6. I authorize and grant permission to Surgicare to send my medical records to my doctor and/or a transferring hospital, pertaining to this procedure as may be necessary.

I certify that I understand the above consent to operation, that all the blank spaces were completed prior to my signing, that I have had an opportunity to ask any questions, that all such questions (if asked) have been answered fully and satisfactorily, and that the explanations referred to have been made

______________________________ ______________________________
Witness Signature of Patient

When patient is a minor, or incompetent to give consent
Signature of person authorized to consent: ______________________________

Relationship to patient: ______________________________

I have explained this procedure to the patient (or person authorized to consent for the patient) and, when appropriate, alternate means of therapy along with the possible resulting risks and complications. I have offered to answer any questions and have fully answered all such questions and have fully answered all such questions. I believe the patient (person signing the form) understands what I have explained and answered.

______________________________M.D. ____________________
Signature Date

______________________________M.D. ____________________
Signature Date