KAISER PERMANENTE®

NAME

PATIENT I.D. NUMBER

DATE OF BIRTH

Consent for low-risk, non-invasive procedure

Washington state law guarantees that you have both the right and obligation to make decisions concerning your health care. Your practitioner can provide you with the necessary information and advice, but as a member of the health care team you must enter into the decision-making process. This form has been designed to acknowledge your acceptance of treatment recommended by your practitioner.

1) I hereby authorize Dr. _____ and/or such associates or assistants as may be selected by said practitioner to treat/evaluate the following condition(s) which has (have) been explained to me: _____

2) The procedures planned for treatment of my condition(s) have been explained to me by my practitioner/or representative. I understand them to be: _____

3) I have been informed of certain risks and complications that can reasonably be anticipated with the procedure described in Paragraph 2. These include, but are not limited to: _____

4) I recognize that, during the course of the procedure, unforeseen conditions may necessitate additional or different procedures than those above set forth. I therefore authorize my above named practitioner, and his or her assistants or designees, to perform such procedures as are in the exercise of his, her or their professional judgement necessary and desirable. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my practitioner at the time the procedure is commenced. I acknowledge that no warranty or guarantee has been made to me.

My practitioner, (insert name) _____, has informed me of the nature and character of the proposed treatment, of the anticipated results of the proposed treatment, of the possible alternative forms of treatment, and any recognized serious possible risks, complications, and the alternative forms of treatment, including non-treatment.

I have had the opportunity to ask questions and have had all aspects of this medical treatment explained to my satisfaction and I consent.

I have read and understand this form. I am the patient or the legally authorized person to sign on the patient's behalf.

_____ _____ _____

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON SIGNATURE DATE TIME

_____ _____ _____ _____

RELATIONSHIP OF LEGALLY RESPONSIBLE PERSON TO PATIENT WITNESS DATE TIME

Consent Distribution of Original: Eastern Washington to ACN-AC3; Western Washington to RCS