

Appendix A

DOWNSTATE MEDICAL CENTER  
STATE UNIVERSITY HOSPITAL

CONSENT TO TREATMENT

NAME

MR #

N.S.

SERVICE/DOCTOR

AFFIX LABEL OR COMPLETE

Date \_\_\_\_\_

Time \_\_\_\_\_ AM  
PM

Patient \_\_\_\_\_

(Last Name)

(First)

(Middle Initial)

Age at Last Birthday \_\_\_\_\_ (Patients under 18 years of age to complete Supplement For Persons under Age 18 Intending to Consent For Themselves)

1. I, \_\_\_\_\_, knowing that I require hospital care or a course of treatment, consent to diagnostic and treatment procedures by State University of New York – Downstate Medical Center physicians or assistants or persons they designate.
2. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me about the benefits or results of procedures and treatments authorized above.
3. I authorize University Hospital to use or dispose of any tissues or specimens resulting from the procedures authorized above.
4. I further consent to the use of confidential information for medical research and education by State University of New York – Downstate Medical Center and their physicians; at the same time the State University of New York – Downstate Medical Center and their physicians are to protect my identity.
5. I have read and understood this form, and I understand that I may ask for further explanations at any time.

Date \_\_\_\_\_

Signature of Patient

If consenting party is other than patient:

\_\_\_\_\_  
(State Relationship to Patient)

Witnesses:

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Address)