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)

UH 4/80 (REV.)