Disclosure and Consent: Medical Procedures
Colposcopy and Cervical Biopsy

TO THE PATIENT: *You have the right as a patient to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

I voluntarily request Dr. , as my physician, and such associates, technical assistants, and other health care providers as they may deem necessary, to treat my condition which has been explained to me as: abnormal PAP smear.

I understand that the following surgical, medical, and/or diagnostic procedures are planned for me, and I voluntarily consent and authorize these procedures: colposcopy and cervical biopsy.

I understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I understand that no warranty or guarantee has been made to me as to result or cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reaction and even death. I also realize that the following risks and hazards may occur in connection with this particular procedure: pain, bleeding, infection.

I have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.

I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.

Date: ________________________________ Time: __________

______________________________________ ______________________________________
Patient/Legal Representative Signature *Witness Signature*

______________________________________ ______________________________________
Patient/Legal Representative Printed Name *Witness Printed Name*

Revised:
Approved:07/28/2014