

MRN: Patient Name: (Patient Label)
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CONSENT FOR SURGERY OR SPECIAL DIAGNOSTIC or THERAPEUTIC PROCEDURE(S)

- 8. UCLA may keep, use or dispose of anything removed during the Procedure ("Specimens"). Specimens may be used for research. I do not own the Specimens, or data derived from Specimens, and have no right to any research or research product using or derived from the Specimens. Specimen includes, but is not limited to, any tissues, organs, bones, bodily fluids, or medical devices.
 - 9. I have the right to consent to or to refuse any proposed operation or procedure, including the Procedure, at any time prior to its performance. I am aware that the practice of medicine and surgery is not an exact science, and no guarantee has been made as to the results of the Procedure or any cure. I also understand that the explanations that I have received may not be exhaustive or all-inclusive and that other more remote risks may be involved. However, the information that I have received is sufficient for me to consent to the Procedure. I have had a full opportunity to ask questions concerning my condition, the Procedure, the risks, and the alternatives. All of the questions that I have asked have been answered to my satisfaction.
 - 10. I understand that if an implantable device is used, information regarding the device and my Social Security Number may be reported to the device manufacturer, if requested, and as required by Federal law.
- 1) I have read and understood the information contained here;
 - 2) I have been informed about the Procedure and the potential risks, benefits, alternatives and the risk of those alternatives;
 - 3) I authorize and consent to the performance of the Procedure as described; and
 - 4) I authorize and direct that any Specimen removed during the Procedure is to be handled as indicated above.

Signature of patient, parent or conservator	Date	Time
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If not signed by patient, indicate relationship or guardian

Witness to Signature	Printed Name of Witness to Signature
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Date	Time
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I have discussed the above information with the patient.

Physician Signature	Date	Time
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