

FACILITY CONSENT

If there is any part of this permit you do not understand, please ask us to explain it.

Patient's Name _____

1. I hereby authorize _____ and his/her associate assistants to perform the following operation: _____

_____ and such other operations or treatments as he deems necessary at this time. The nature and purpose of the operation, possible alternative methods of treatment, the risks involved, the possible consequences, and the possibility of complications have been explained to me by my physician. He has not guaranteed success of the operation.

2. I consent to the administration of anesthesia and/or medications as deemed necessary by _____ and/or my admitting physician.

3. I agree to allow any tissue or other body parts removed from my body to be examined by a pathologist if my physician says it is medically necessary. I agree to pay the usual charge made by the pathologist.

4. I agree to allow x-rays to be taken and read by a radiologist if necessary. I agree to pay the usual charge made by the radiologist.

5. I consent to the photographing or videotaping of the operations or procedures to be performed for medical or educational purposes, provided my identify is not revealed by the pictures or by descriptive texts accompanying them.

6. For the purpose of advancing medical knowledge, I consent to the admittance of qualified observers in the operating room.

7. I understand that I am going home after surgery and if my procedure involves other than local or topical anesthesia, I must have another adult to drive me home and take care of me.

8. I understand that the surgical and/or diagnostic procedure to be performed on me at this facility will be done on an outpatient basis and that this facility does not provide 24-hour patient care. If my attending practitioner, or any other duly qualified physician in his/her absence, shall find it necessary or advisable to transfer me from this facility to a hospital or other health care facility, I consent and authorize the employees of this facility to arrange for and effect the transfer.

9. I shall carefully read and abide by all post-operative instructions given to me by this facility and I shall keep all follow-up appointments that are made for me.

10. I agree to let this facility send a copy of my medical record to my insurance company or other responsible party if they request it.

11. A copy of this permit shall be considered as effective and valid as the original.

12. My signature below constitutes my acknowledgement: (1) That I have read and agree to the foregoing; (2) That the operations or special procedures have been adequately explained to me by my attending physicians or surgeons and that I have all the information that I desire.

Signature of Patient

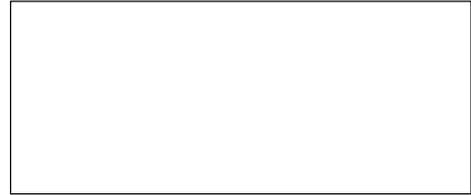
Date

Signature of Person Authorized to Consent for Patient

Witness

Relationship to Patient

**PACIFIC SURGERY CENTER OF SANTA MONICA
 CONSENT FOR ANESTHETIC SERVICES**



I, _____, acknowledge that my doctor has explained to me that I will have an operation. My doctor has explained the risks of the procedure, advised me of alternative treatments, and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anesthesia services are needed so that my doctor can perform the procedure. It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected severe complications with anesthesia can occur and include the remote possibility of **infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death**. I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the type(s) of anesthesia service checked below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, my doctor's preference, and my own preference. It has been explained to me that sometimes an anesthesia technique which involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia.

A board certified anesthesiologist properly credentialed to work at Pacific Surgery Center of Santa Monica will be providing anesthesia services for my procedure. The type of anesthesia I will be receiving is:

Anesthesia Type	Description
<input type="checkbox"/> Monitored Anesthesia Care with Sedation	One or more hypnotic or sedative drugs will be given intravenously with the goal of reduced consciousness and total or partial amnesia. Vital signs will be closely monitored and an anesthesiologist will be present. Specific risks include an unconscious state, or depressed breathing requiring further intervention.
<input type="checkbox"/> Peri-orbital injection (nerve block) <ul style="list-style-type: none"> <input type="checkbox"/> Retrobulbar <input type="checkbox"/> Peribulbar or Subtenon's 	An injection of local anesthetic is given around the eye to numb the eye and prevent eye movement. Risks of peri-orbital injection include needle damage to the eyeball or optic nerve, which could cause loss of vision; interference with circulation of the retina, which could cause loss of vision; drooping of the eyelid; damage to the eye muscles, double vision; and bruising of the skin around the eyes. Rarely depressed breathing can occur.

<input type="checkbox"/> General Anesthesia	Medication is given through the IV and/or inhaled through the lungs to induce an unconscious state. A breathing tube or similar device is inserted to breath for the patient with the help of a ventilator. Specific additional risks include mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration, pneumonia
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I hereby consent to the anesthesia service checked above and authorize that it be administered by _____, or his/her associates, all of whom are credentialed to provide anesthesia services at this healthcare facility. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by them.

I expressly desire the following considerations be observed (or write "none"):

I certify and acknowledge that I have read this form or had it read to me; that I understand the risks, alternatives and expected results of the anesthesia service; and that I had ample time to ask questions and to consider my decision.

Patient's Signature

Date and Time

Substitute's Signature (if applicable)

Relationship to Patient

Anesthesiologist Signature

Date and Time

Witness

Date and Time



Preoperative Facility Disclosure

QUAD A PATIENTS' BILL OF RIGHTS

This accredited facility presents these Patient Rights and Patient Responsibilities to reflect the commitment to providing quality patient care, facilitating dialogue between patients, their physicians, and the facility management, and promoting satisfaction among the patients and their designated support person(s), physicians, and health professionals who collaborate in the provision of care. This facility recognizes that a personal relationship between the physician and the patient is an essential component for the provision of proper medical care. When the medical care is rendered within an organizational structure, the facility itself has a responsibility to the patient to advocate for expanded personal relationships and open communications between patients and their designated support persons, physicians and the organization's staff members. This facility has many functions to perform, including but not limited to, preventing and treating medical conditions, providing education to health professionals and patients, and conducting clinical research. All these activities must be conducted with an overriding concern for the patient and above all the recognition of his or her dignity as a human being. Although no catalogue of rights can provide a guarantee that the patient will receive the kind of treatment he or she has a right to expect, these patient rights are affirmed and actively incorporated into the care provided in this facility.

Patient Rights:

1. The patient has the right to receive considerate and respectful care in a safe setting.
2. The patient has the right to know the name of the physician responsible for coordinating his/her care.
3. The patient has the right to obtain information from his or her physician in terms that can be reasonably understood. Information may include, but is not limited to his or her diagnosis, treatment, prognosis, and medically significant alternatives for care or treatment that may be available. When it is not medically advisable to share specific information with the patient, the information should be made available to an appropriate person in his or her behalf. When medical alternatives are to be incorporated into the plan of care, the patient has the right to know the name of the person(s) responsible for the procedures and/or treatments.
4. The patient has the right to obtain the necessary information from his or her physician to give informed consent before the start of any procedure and/or treatment. Necessary information includes, but is not limited to, the specific procedure and/or treatment, the probable duration of incapacitation, the medically significant risks involved, and provisions for emergency care.
5. The patient has the right to expect this accredited ambulatory surgery facility will provide evaluation, services and/or referrals as indicated for urgent situations. When medically permissible, the patient or designated support person(s) will receive complete information and explanation about the need for and alternatives to transferring to another facility. The facility to which the patient is to be transferred must first have accepted the patient for transfer.
6. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his or her action.
7. The patient has the right to obtain information about any financial and/or professional relationship that exists between this facility and other health care and educational institutions insofar as his or her care is concerned. The patient has the right to obtain information about any professional relationships that exist among individuals who are involved in his or her procedure or treatment.
8. The patient has a right to be advised if this accredited ambulatory surgery facility proposes to engage in or perform human experimentation affecting his or her care or treatment. The patient has the right to refuse to participate in research projects.
9. The patient has the right to every consideration for privacy throughout his or her medical care experience, including but not limited to, the following. Confidentiality and discreet conduct during case discussions, consultations, examinations, and treatments. Those not directly involved in his or her care must have the permission of the patient to be present. All communications and records pertaining to the patient's care will be treated as confidential.
10. The patient has the right to expect reasonable continuity of care, including, but not limited to the following. The right to know in advance what appointment times and physicians are available and where. The right to have access to information from his or her physician regarding continuing health care requirements following discharge. The number to call for questions or emergency care
11. The patient has the right to access and examine an explanation of his or her bill regardless of the source of payment.
12. The patient and designated support person(s) have the right to know what facility rules and regulations apply to their conduct as a patient and guest during all phases of treatment.
13. The patient has the right to be free from all forms of abuse, neglect, or harassment.
14. The patient has the right to exercise his or her rights without being subjected to discrimination or reprisal.

Patient Responsibilities:

1. It is the patient's responsibility to participate fully in decisions involving his or her own health care and to accept the consequences of these decisions if complications occur.
2. It is the patient's responsibility to follow up on his or her physician's instructions, take medications when prescribed, and ask questions that emerge concerning his or her own health care.
3. It is the patient's responsibility to provide name of support person in case of emergency and have this support person available when advised to do so.

Direct any care concerns or complaints to:

Facility Director: Christian Sanfilippo MD
Phone: 424-413-1179

And the Investigations Team at QUAD A
Phone: (888) 545-5222
Email: investigations@quada.org

Department of Health: Los Angeles County
Phone: 213—240-7821

Office of the Medicare Beneficiary Ombudsman
Phone: 1-800-MEDICARE (1-800-633-4227)
Website: <https://www.cms.gov/center/special-topic/ombudsman/medicare-beneficiary-ombudsman-home>

Advance Directives

Regardless of any Advance Directive or instructions from a health care surrogate or Power of Attorney, an unexpected medical emergency, which occurs during treatment at this facility, will be aggressively managed with resuscitative or other stabilizing measures followed by emergency transfer to the closest emergency room. The receiving hospital will implement further treatment or withdrawal of treatment measures already begun in accordance with patient wishes, Advance Directive, or healthcare Power of Attorney. Acknowledgement of this policy does not revoke or invalidate any current healthcare directive or healthcare Power of Attorney. You can download Advance Directive forms from the following website: <https://www.caringinfo.org/planning/advance-directives/by-state/>

Financial Disclosure

We are required by law to inform you of this ownership interest. You have the right to choose the provider of your health care services, including the facility where your procedure will be performed. You may elect to have your procedure performed at a different facility, if you prefer.

Physician(s) with Ownership Interest: Amir Guerami MD, Christian Sanfilippo MD, Hajir Dadgostar MD, Ph.D

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our facility. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of Protected Health Information (PHI).

The Law Requires Us To:

- Keep your medical information private.
- Give you this notice describing our legal duties, privacy practices and your right regarding your PHI.
- Follow the terms of the notice that is now in effect.
- Notify you if a breach in the security of your Protected Health Information (PHI) occurs.

We Have the Right To:

Change our privacy practices and the terms of this notice at any time, as long as they are permitted by law. This includes information previously created or received before those changes. Notification will occur if any important change is made, and will be available upon request.

Use and Disclosure of Your Protected Health Information (PHI):

The following section describes different ways that we use your PHI. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose PHI. We will not disclose any of your PHI for any purpose not listed below, without your specific written authorization. Any specific written authorization may be revoked at anytime by writing to us. We are required to obtain your authorization prior to disclosing PHI related to psychotherapy notes, sale of PHI or marketing.

FOR TREATMENT: We may use PHI about you to provide you with medical treatment or services. We may disclose this information about you to doctors, nurses, technicians and other people taking care of you. We may also share your PHI with other health care providers to assist them in treating you.

FOR PAYMENT: We may use PHI to obtain payment for the services we provide.

FOR HEALTH CARE OPERATIONS: We may use and disclose your PHI for our health care operations. This might include quality improvement measures, evaluating performance of employees, staff training, accreditation, obtaining certificates and licensure that we need in order to operate. This also includes business management and administrative activities.

NOTICE OF PRIVACY PRACTICES

OTHER USES AND DISCLOSURES: As part of treatment, payment and health care operations, we may also use or disclose your PHI for the following purposes:

Appointment Reminders: PHI used to contact you, a family member or other responsible person, as a reminder that you have an appointment for surgery at Pacific Surgery Center of Santa Monica. We will use the phone number(s) given to us by your surgeon's office and may leave a message with a family member. We will limit the PHI disclosed when leaving a message. If you prefer we use a different phone number, not leave messages, or prefer we do not speak with family members, this can be requested by contacting the privacy officer, in writing, at the address below.

Notification: PHI used to notify or help notify a family member or other person responsible for your care. We will share information about your location in our facility, general condition and approximate wait time. If you are present, we will get your permission if possible, before we share this information. In case of emergency and/or if you are not able to give or refuse permission, we will share only the PHI that is directly necessary for your health care, according to our professional judgment to make decisions in your best interest.

Disaster Relief: PHI will be shared with a public or private organizations or persons who can legally assist in disaster relief efforts.

Fundraising: We may contact you to raise funds for the facility or an institutional foundation related to the facility. You have the right to opt out. If you do not wish to be contacted, please contact our Privacy Officer.

Research in Limited Circumstances: PHI for research purposes in limited circumstances where the research has been approved by the Governing Body. They will review the research proposal and established protocols to ensure the privacy of your PHI.

Funeral Director, Coroner, Medical Examiner and Organ Donation: We may disclose PHI of a person who has died with these entities in order to help them carry out their duties.

Specialized Government Functions: Subject to certain requirements, we may disclose and/or use PHI for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of the State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial Administrative Proceedings: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request or other lawful process. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may share your PHI with law enforcement officials. We may share limited information with law enforcement officials concerning the medical information of a suspect, fugitive, material witness, crime or missing person. We may also share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

NOTICE OF PRIVACY PRACTICES

Public Health Activities: As required by law, we may disclose your PHI to public health or official authorities charged with preventing or controlling disease, injury or disability, including suspected physical abuse, neglect or domestic violence. We may also disclose your PHI to the Food and Drug Administration for purposes or reporting adverse events associated with product defects, problems, tracking and other activities. We may also, when authorized by the law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk or contracting or spreading a disease or condition.

YOUR RIGHTS:

- The right to inspect and copy your PHI, via written request to the Privacy Officer. We may deny your request, if in our professional judgment, we determine that the access requested will endanger your life or another's.
- The right to request a restriction on uses and disclosures of your PHI.
- The right to request to receive confidential communications from us by alternative means or locations.
- The right to request amendments to your PHI in writing with reasons to support such a request. In certain cases, we may deny your request for an amendment.
- The right to receive an accounting of certain disclosures for purposes of treatment, payment or health care operations. These written requests must be submitted to our Privacy Officer. Requests may not be for a period more than 6 years. We will provide the first request within any 12-month charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.
- The right to request that Pacific Surgery Center of Santa Monica not disclose your PHI to your health plan for the purposes of payment or healthcare operations, and if you are paying for your treatment out of pocket in full, then the facility must honor your requested restriction.
- The right to obtain a paper copy of this notice.
- The right to revoke your authorization of PHI release at any time.

Contact Person:

Attn: Privacy Officer

Pacific Surgery Center of Santa Monica

2021 Santa Monica Blvd Ste 724E Santa Monica, CA 90404

The Privacy Officer can be contacted by telephone at (424) 413-1179

This notice is effective January 1, 2024.

Privacy Practices Acknowledgement

By signing this form, you acknowledge that you have been informed that Pacific Surgery Center of Santa Monica (PSCSM) provides information about how we may use and disclose your Protected Health Information (PHI). We encourage you to read the "Notice of Privacy Practices" posted in our lobby. If you would like a paper copy, please ask the receptionist.

Pacific Surgery Center of Santa Monica may use the following methods of communication regarding information related to my personal health, treatment or payment for treatment. I acknowledge I am responsible for updating this information as necessary. This request supersedes any prior request for methods of communication I may have made.

- Contact me by phone at home _____
- Work _____ Cell _____
- PSCSM may leave a message on my voice mail/answering machine
- PSCSM may speak to anyone who answers the phone
- PSCSM may only speak to _____
- PSCSM may leave a message for me at my work phone number

Questions or concerns about our Privacy Notice or Practices should be directed to the Privacy Officer at (424) 413-1179

Signature _____ Date _____
(Patient/Parent/Conservator/Guardian) (Mo/Day/Yr)

Inability to obtain acknowledgement: *To be completed only if no signature is obtained:*

- Patient lacks the ability to understand the Notice of Privacy Practices
- Other _____

Signature _____ Date _____
(Provider Representative) (Mo/Day/Yr)

Patient Label/Printed Name _____

Patient Notification and Acknowledgement

Notice of Rights

Pacific Surgery Center of Santa Monica has established a Patient's Bill of Rights, which is provided verbally and in writing in a language and manner the patient or patient's representative understands prior to the date of the procedure. Pacific Surgery Center of Santa Monica expects that observance of these rights will contribute to more effective patient care and greater satisfaction for patients, physicians, and the facility.

Financial Disclosure

Pacific Surgery Center of Santa Monica is privately owned by Dr. Christian Sanfilippo, Dr. Hajir Dadgostar, Dr. Amir Guerami and has informed the patient prior to the date of the procedure that their physician may have a proprietary interest in this facility. The patient has the right to choose the facility of his/her choice for health-related services.

Advance Directives

Because the scope of Pacific Surgery Center of Santa Monica is limited to elective outpatient surgical procedures, it is the policy of this facility, that any life-threatening situation that arises will be immediately treated with life-sustaining measures. Concurrently, the emergency medical system (EMS) will be activated for emergency patient transport to a hospital facility. The patient's right and need to be an active participant in the decision-making process regarding their care is recognized and respected. Acknowledgement of this policy does not revoke or invalidate any current health care directive or health care power of attorney.

Please check the appropriate box. Have you executed an advance health care directive, a living will and/or a power of attorney that authorizes someone to make health care decisions for you?

- Yes**, I have an advance health care directive, living will and/or a power of attorney.
- I have provided a copy of my advance health care directive, living will and/or a power of attorney.
- No**, I do not have an advance health care directive, living will and/or a power of attorney.
- I would like additional information on advance health care directives.

By signing this document, I acknowledge that the above information was given to me prior to my day of surgery, and that I have read and understand the information on notice of privacy practices, patient rights, financial disclosure and advance directives. I agree to the policies of Pacific Surgery Center of Santa Monica. If I have indicated I would like additional information, I acknowledge receipt of that information.

Patient Signature (If patient is unable to sign, please indicate relationship)

Date

Witness Signature

Date

Patient Sticker

PACIFIC SURGERY CENTER OF SANTA MONICA

2021 Santa Monica Blvd Suite 724E Santa Monica, CA 90404
P: 424-413-1179

1. The patient is responsible for providing accurate, complete and current medical information. This includes current complaints, past illnesses, hospitalizations, medications and other matters relating to current health status. ____
2. The patient is responsible for following the treatment plan recommended by our surgeons, nurses and anesthesia providers. ____
3. The patient is responsible for their actions if refusing treatment, or if they do not follow the recommendation of our surgeons, nurses and anesthesia providers. ____
4. The patient is financially responsible for the surgical procedure performed. ____
5. The patient is responsible for following the preoperative, intraoperative and postoperative instructions given by our surgeons, nurses and anesthesia providers. ____
6. The patient is responsible for reporting unexpected changes in their condition to their surgeon. ____
7. The patient is responsible for notifying their surgeon, nurse and/or anesthesia provider if they do not understand the planned treatment or if they have not received appropriate preoperative instructions. ____

Patient Name: _____

Patient Signature: _____

Date: _____

Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name (print)

Medicare Number

- 1 **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Pacific Surgery Center of Santa Monica (PSCSM) for services furnished to me by PSCSM. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If a secondary insurance is listed, my signature authorizes releasing the information to the insurer or agency shown. PSCSM accepts the charge determination of the Medicare carrier as the full charge and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.
- 2 **MEDIGAP:** I understand that if a medigap policy or other health insurance is indicated, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to PSCSM, if possible or otherwise to me.
- 3 **RELEASE OF INFORMATION:** PSCSM may disclose all or part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV to any person or corporation (1) which is or may be liable under contract to PSCSM for reimbursement for services rendered and (2) any health care provider for continued patient care. PSCSM may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, and medical research, for the collection of statistical data or pursuant to State or Federal Law, statute or regulation. A copy of this authorization may be used in place of the original.
- 4 **OTHER INSURANCE:** I understand that PSCSM maintains a list of health care plans with which it contracts. A list of such plans is available from the business office. And that PSCSM has no contract, expressed or implied with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by PSCSM if he/she belongs to a plan that does not appear on the above mentioned list.
- 5 **NON COVERED SERVICES:** I understand that PSCSM's contracts with health care service plans (ie. HMOs, PPOs) relate only to items and services which are "covered" by the health care services plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non covered services include, but are not limited to, services not specified as being covered in the patient's contract with health care service plan or in the benefit summary the health care service plan furnishes to the patient: and treatment or test not authorized by the health care service plan. The undersigned agrees to cooperate with PSCSM to obtain necessary health care service plan authorizations.
- 6 **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by PSCSM, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to PSCSM for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, liable to the patient, is hereby assigned to PSCSM. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to PSCSM. However, it is understood that the undersigned and/or patient are primarily responsible for the payment of the patient's bill.

Beneficiary Signature or Authorized Party

Date

AUTHORIZATION AND CONSENT FOR
PHOTOGRAPHY AND PUBLICATION

The undersigned hereby authorizes Pacific Surgery Center of Santa Monica and the attending physician to record video of the surgery performed on _____ while under the care of _____. The undersigned agrees that the above named Pacific Surgery Center of Santa Monica and the attending physician may use and permit other persons to use the recordings for such purposes and in such manner, as either may deem appropriate. The undersigned agrees the videos may be used for purposes including, but not limited to education, research, scientific publications, and that such dissemination may be accomplished in any manner and that such use is subject only to the following limitations:

The undersigned has entered into this agreement in order to assist scientific discovery, and educational goals, and hereby waives any right to compensation for such uses by reason of the foregoing authorizations, and the undersigned and his successors or assigns hereby hold the above named facility and the attending physician and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

Patient Signature

Date

Time

If signed by other than patient, indicate relationship

Witness