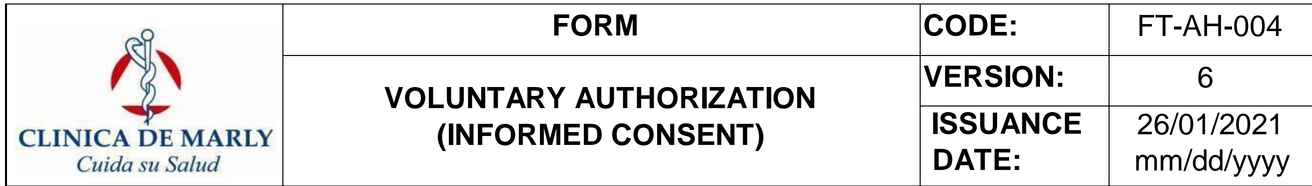

CLINICA DE MARLY Cuida su Salud	FORM	CODE:	FT-AH-004
	VOLUNTARY AUTHORIZATION (INFORMED CONSENT)	VERSION:	6
		ISSUANCE DATE:	26/01/2021 mm/dd/yyyy

For the supply of medical services, surgical interventions or special procedures.

Date: ____________________________ Medical Record No. ________________________

In full use of my mental faculties, I am hereby authorizing the doctor ____ and the assistants he selects to perform on me or on the patient named ____ the following intervention or special procedure: ____

Possible alternatives of the proposed treatment have been explained to me and I have had the opportunity to ask questions and all of them have been satisfactorily answered.

I am hereby authorizing the CLINICA DE MARLY and its specialists to use in this intervention or procedure and during the post-operative period, the necessary medications, anesthetic techniques or contrast imaging.

I acknowledge that there are risks to my life and health associated with these procedures and/or contrast imaging. These risks have been explained to me by the specialist doctor. I understand that during the intervention or special procedure, unexpected situations may arise that may require additional procedures. I authorize these procedures, if the physician or his/her assistants believe they are necessary.

I authorize the CLINICA DE MARLY to take tissue or organic fluid samples to perform lab tests or histopathological tests.

I acknowledge that the results expected from this intervention or procedure have not been guaranteed to me whereas this is an activity of means and not results, taking into consideration that all available technical scientific elements and any other quality parameters for its execution will be used.

I hereby certify that I have read and understood the aforementioned, that all blank spaces were already completed when I signed this document and that I am able to freely make a decision in this regard. After the medical examination conducted by the Treating Physician and the pertinent medical lab exams, the type and purpose of this intervention or special procedure have been explained to me, as well as any complications and risks that may be produced as follows:____
____
____,
as well as the following benefits:____

______________________________________	______________________________________
Name of the Patient ID No.:	Signature ID Type:
______________________________________	______________________________________
Name of the Witness or relative/guardian* *Kinship:	Signature ID No.:
______________________________________	______________________________________
Name of Physician	Signature ID No.:

We certify that we have explained the type, purpose, benefits, risks and alternatives of the proposed intervention or special procedure and we have answered all questions asked. We consider that the patient, relative/guardian understands what we have explained.

This document shall be included in the Patient’s Medical Record.