RONA Z. SILKISS
M.D., FACS
OCULOFACIAL PLASTIC, RECONSTRUCTIVE AND ORBITAL SURGERY

ADMINISTRATIVE OFFICE
400 29th Street, Suite 315
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Phone 510.763.0881
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Consent for Surgery

PATIENT'S NAME:____

I authorize Rona Z. Silkiss, M.D. and such other associates as may be selected by her, to perform the following surgery, including the administration of anesthesia (local/intravenous sedation)

____

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The nature and purpose of the surgical procedure, possible alternative methods of treatment, the risks involved, and the possible complications have been explained to me by my physician. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

My signature below constitutes my acknowledgment:
1. THAT I HAVE READ AND AGREED TO THE FOREGOING.
2. THAT THE PROPOSED SURGICAL PROCEDURE HAS BEEN EXPLAINED TO ME AND THAT I HAVE ALL THE INFORMATION I DESIRE.
3. THAT I HEREBY GIVE MY AUTHORIZATION AND CONSENT.

Signed: ____
Patient or person authorized to sign for patient

______________________________________ ____________
Relationship to patient if other than self Date

______________________________________ ____________
Witness Date

PATIENT CONSENT FORM

In connection with the medical services received from the above named physician, I consent that photographs, movies, or videotapes may be taken of me to be used for medical records and publications (in print or by broadcast) for the purposes of medical education, under private or commercial sponsorship, provided I am not identified by name. I waive all rights to claim for payment or royalties in connection with the above publication or broadcast.

______________________________________ ____________
Patient Date

______________________________________ ____________
Witness Date