UNIVERSITY PHYSICIANS

DIGESTIVE DISEASE CENTER & ENDOSCOPY CENTER

University Physicians of Brooklyn
760 Parkside Avenue, Brooklyn, N.Y. 11226

GENERAL CONSENT TO TREATMENT

I, Knowing that I require hospital care or a course of treatment, consent to diagnostic treatment procedures by the University Physicians of Brooklyn, Inc. or assistants or person(s) they designate.

I am aware that the practice of medicine is not an exact science. No guarantees have been made to me about the benefits or results of procedures and treatments authorized above.

I authorize University Physicians of Brooklyn, Inc., to use or dispose of any tissues or specimens resulting from the procedure(s) authorized above.

I further consent to the use of patient information for training and education purposes by University Physicians of Brooklyn, Inc., SUNY Downstate, University Hospital of Brooklyn and their physicians; at the same time University Physicians of Brooklyn, Inc., SUNY Downstate, University Hospital of Brooklyn are to protect my identity.

By signing this consent form, I hereby authorize the hospital and its medical staff to use and disclose my personal health information, as necessary for the purposes of obtaining medical treatment, enabling the hospital and its staff to obtain payment for such treatment and for the normal business operations of the hospital.

I have read and understood this form and I understand that I may ask for further explanations at any time.

Patient's Name (Print)	**Signature**	**Date**

If the patient cannot consent for him/herself, the signature of either the health care agent or legal guardian who is acting on behalf of the patient or the next-of-kin who is assenting to the treatment for the patient must be obtained.

Health Care Agent/Guardian (Print)	**Signature/Relationship**	**Date**

WITNESS: To be signed by a facility employee who is not the patient's health care provider. I have witnessed the patient or other appropriate person voluntarily sign this form.

Witness's Name (Print) Signature
Date

Indicate if applicable: [ ] Patient is unable to sign, and next-of-kin is unavailable [ ] Patient refused to sign

INTERPRETER/TRANSLATOR: To be signed by the interpreter/translator if the patient required such assistance. To the best of my knowledge, the patient understood what was interpreted/translated and voluntarily signed this form.

Interpreter/Translator's Name (Print) Signature
Date