CONSENT FOR TREATMENT

Patient Name: _____ Date of Birth: _____

Urologic Associates of Western Pennsylvania, Physician Name: _____

I request those physicians and other healthcare professionals who care for me to perform routine diagnostic procedures, and therapeutic treatments, which in their judgment, become necessary while I am being treated by the Physician Practice named above. Routine diagnostic procedures and medical treatments include but are not limited to blood work, Radiological testing, administration of medications and procedures.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations. I authorize the Physician Practice named above to retain, preserve and use for scientific, or educational purposes, or dispose of at their convenience, any specimens or tissue taken from my body during the visit. If I undergo any procedure that requires the submission of tissue for pathologic examination, I authorize the use of any excess tissue for educational purposes.

I CERTIFY THAT I HAVE READ THIS FORM AND THAT I UNDERSTAND ITS CONTENTS.

_____ _____

Patient Signature Witness Signature

_____

Substitute Decision Maker

_____ _____

If Substitute Decision Maker, state relationship Date/Time