



OREgon Surgery Center

FACILITY INFORMED CONSENT

2801 N W Mercy Drive, Suite 200
Roseburg, OR 97470
Telephone (541) 677-2800
Fax (541) 677-2820

NAME OF PATIENT _____ **ORSC NUMBER** _____

I hereby consent to outpatient surgery, administration of drugs and solutions, laboratory studies, x-ray examinations or other medical or surgical treatment as may be rendered to _____ (myself or patient's name) under the general and special instructions of Dr. _____, his assistants or designees.

I understand that my care is under the control of my admitting physician(s) and that **in rare situations an anesthesiologist or radiologist may be requested to participate in my care without my express written permission. I fully accept such decision by my admitting physician(s).**

I understand that ALL DOCTORS AND DENTISTS FURNISHING SERVICES TO ME, INCLUDING THE ANESTHESIOLOGIST, RADIOLOGIST, AND PATHOLOGIST ARE INDEPENDENT CONTRACTORS AND ARE NOT EMPLOYEES OR AGENTS OF OREGON SURGERY CENTER.

IN CASE OF EMERGENCY PLEASE NOTIFY THE FOLLOWING FAMILY MEMBER

Name _____ **Relationship** _____

Tel. Number _____ **and/or Cell Phone #** _____

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| <p>Signature of Patient or Authorized Person _____</p> <p>Relationship of Authorized Person to Patient _____</p> <p>Date Signed _____</p> <p>Time Signed _____</p> <p>Witness _____</p> |
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PATIENT IDENTIFICATION