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|  | 400 Ashville Ave. Ste. 200  Cary, NC 27518  Ph: 919-233-1680  Fax: 919-233-1685 |

**Consent to proceed for Tubal Reversal Surgery without submitting my prior tubal ligation Medical records.**

**I**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to proceed with

Tubal reversal surgery at (NCCRM) without submitting my previous medical records and the

operative notes for my prior tubal ligation procedure. I request and authorize the physicians

and the staff at NCCRM to perform any diagnostic procedures, treatment procedures, and

operative procedures related to the tubal reversal surgery. I also have not been given a

guarantee as to the results of surgery without having my prior records and the tubes may be

too short to repair or absent.

I release NCCRM and its staff from any claim or liability due to the proceeding for tubal

reversal surgery without having my prior records.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_