THE MOUNT SINAI HOSPITAL
NEW YORK, N. Y.

PERMISSION SHEET # 1

[redacted]
U- 1040588 F/ 14
S- 4035499 S 3

DATE
NAME
UNIT NO & SEX / AGE
SERIAL NO LOCATION
PHYSICIAN & SERVICE

PERMISSION FOR OPERATION AND/OR TREATMENT

New York, 11-12 1975

I, the undersigned, hereby authorize Dr. Hollin S
(and whomever he may designate as his assistants) to perform the following operations:

Craniotomy and Clipping of Intra
Cranial Aneurysm.

I consent to the performance of operations and procedures in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions, which the above named doctor or his assistants may consider necessary or advisable in the course of the operation. Any tissues or parts surgically removed may be disposed of by the Hospital in accordance with accustomed practice.

I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for this service except for:

None
(Write "none" if no exceptions)

I consent to the photographing or televising of the operations or procedures to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my name is not revealed by the pictures or by the descriptive texts accompanying them. For the purpose of advancing medical education, I consent to the admittance of observers to the operating room.

I also consent to the administration of such treatments, procedures, and/or x-rays as the above named doctor, or his associates, or any other designated Hospital personnel deem necessary.

I hereby certify that I have read and fully understand the above, the reasons why the surgery and/or treatment is considered necessary, its advantages and possible complications, if any, as well as possible alternate modes of treatment, which were fully explained to me.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

I do hereby release The Mount Sinai Hospital, its physicians, nurses and attendants from any and all claims which I may at any time have in connection with or as a result of such operation or procedure.

J. Gamble R
(Witness)

Signed [redacted]
FATHER
(Relationship)

C-2-E-3
MSH 10M

FOR SPANISH SPEAKING PATIENTS, USE REVERSE SIDE.
PARA LOS PACIENTES QUE HABLAN ESPAÑOL, VEASE EL REVERSO.

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