Dr. Kelly Rogers DPM
Podiatric Medicine – Podiatric Surgery
535 Main Street, Olean NY Phone: (716) 376-2282 Fax: (716) 376-2281

Patient: _____ DOB: _____

DATE: _____TIME: _____ PLACE: _____

1. I hereby authorize **Dr. Kelly Rogers** and whoever he may designate as assistants to perform upon myself the following operation/ procedure:
   _____
   _____
   _____
   and if during the course of such operation other or different operative procedures, in his sole discretion appear advisable, to perform such other or different procedures as if they had herein been specifically authorized.
2. The nature and purpose of the operation, possible alternative measures of treatment, the risk involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantee of assurance has been made to the results that may be obtained. I understand that there is a danger that certain unfavorable results may follow, namely **Infection, recurrence, swelling, numbness, pain and drainage.**
3. I consent to the administration of anesthesia to be applied by under the direction of **Dr. Kelly Rogers** to the use of such anesthetics as he may seem advisable, with the exception of **NONE.**
4. I consent to the disposal by **Dr. Kelly Rogers** or whoever he may designate of any tissue or parts which may be removed.
5. For the purpose of advancing medical education, I consent to the admittance of observers to the operating room.
6. I am allergic to the following medications: _____
   _____
7. I certify that I have read and fully understand the above consent to operation, that the explanations therein referred to were made, and that all blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken in my presence and before I signed.

Patient Signature: _____Date/ Time: _____

Legal Guardian (if Minor): _____Date/Time: _____

Witness: _____Date/Time: _____

Doctor Signature: _____Date/Time: _____