

Medical Procedure Risk Waiver Form

Patient Information

Full Name:

Date of Birth:

Phone Number:

Address:

Medical Procedure

Name/Description of Procedure:

Date of Procedure:

Risk Awareness & Waiver

Please describe the risks as explained to you:

Questions/Concerns Discussed:

By signing this form, I acknowledge that I have been informed of the nature, purpose, and potential risks of the procedure. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I understand and voluntarily accept all associated risks and waive any claim against the provider for complications arising from the procedure, except those arising from gross negligence.

Patient Signature
Date:

Witness/Provider Signature
Date:
