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SYDNEY R. COLEMAN, M.D.

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**Patient's Consent and Release Statement**

I, the undersigned, \_\_\_\_\_, request the following operation

Placement of my own fatty tissue into my

Removal of my own fatty tissue from

to be performed upon myself by Dr. Sydney Reese Coleman and such operations or treatments as in the judgment of Dr. Coleman are indicated.

**Dr. Coleman has placed markings onto my face and/or body. I have examined these markings completely with Dr Coleman and I understand that they represent the location for the placement and/or removal of fat and the planned incisions.** I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

I understand and acknowledge that in rendering treatment to me, Dr. Coleman undertakes to exercise his best skills and judgment as a physician and surgeon, but does not warrant, guarantee or make any special contract or promise with respect to the result of this operation or any operations or treatment which shall be given to me.

I understand that this surgery is purely elective and Dr. Coleman has fully explained to me the nature and purpose of the procedure and has also informed me of the expected benefits and complications, attendant discomforts and risks that may arise. Dr. Coleman and I have planned and fully discussed my procedure.

I authorize Dr Coleman to disclose complete information concerning medical findings and treatment of the undersigned, from the initial office visit date until the date of conclusion of such treatment to those individuals who in Dr Coleman's sole determination are required to receive such information for the purpose of medical treatment medical quality assurance and peer review

I authorize Dr. Coleman to dispose of any unused tissue during the course of this procedure.

I also authorize \_\_\_\_\_ M.D., to provide local and /or regional anesthesia with sedation to me prior to and during the procedure. I understand that \_\_\_\_\_ M.D., will manage my anesthesia care and recovery for this procedure.

Signed: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: