SARASOTA MEMORIAL HOSPITAL
PATIENT CONSENT FOR VISITOR - OBSERVER IN THE OPERATING ROOM

TO: SARASOTA MEMORIAL HOSPITAL

I, _____, patient of Dr. _____,
Print name of patient Print name of surgeon
do agree that _____ be allowed and permitted to be present
Print name of visitor
and observe in the Operating Room at the time surgery is being performed on me by the aforesaid surgeon.

- By this consent, I expressly release the Sarasota County Public Hospital Board, Sarasota Memorial Hospital, its staff, employees and agents, and attending physicians from any and all liability, claims or causes or action of any kind whatsoever resulting from the presence of such person in the operating room at the time of my surgery.

- This Release and Consent is being given for the purpose of allowing the above named visitor the opportunity to observe only, as a means to expand and increase his or her knowledge of care of the patient in surgery.

- This Release and Consent shall be binding upon the heirs, executors, and personal representatives of the undersigned.

Signature of Patient Date/Time	Signature of Witness (must be an adult) Date
Printed name of Patient	Printed Name of Witness
Signature of parent (s) or legally authorized representative if patient is a minor Date	
Printed Name of parent (s) or legally authorized representative	Patient ID Label