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HYSTERECTOMY – INFORMED CONSENT

This is to certify that I _____ have been advised by
(name of patient)

my physician _____ that the hysterectomy which will
(name of physician)

be performed on me will render me permanently sterile and incapable of having children. I have been informed of my rights to consultation by a second physician prior to having this operation.

_____ ____/___/____
Patient Signature Date

_____ ____/___/____
Physician Signature Date