

Hysterectomy Consent Form

I understand that my hysterectomy, to be performed by Doctor _____ will render me permanently incapable of reproducing.

Date: _____ Signature of beneficiary or representative: _____

Beneficiary address: _____

I certify that the hysterectomy I performed for _____ beneficiary's name was not performed solely or primarily in order to render her permanently incapable of reproducing.

Date: _____ Signature of physician: _____

TO THE SURGEON, ASSISTANT SURGEON, ANESTHESIOLOGIST, HOSPITAL, CLINIC, ETC.: A copy of this form, properly completed and signed, must be attached to your billing form to authorize medical payment.