

MEDICAL RECORD**Informed Consent to Voluntary Sterilization**

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____
Name of Person Obtaining Consent

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision would not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds such as A.F.D.C. or Medicaid that I am now getting, or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN, OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.

I am at least 21 years of age and was born on _____, I, _____, hereby consent
Month/Day/Year
of my own free will to be sterilized by _____ by a method called _____
Doctor

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services or
- Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form: _____
Patient Signature Month/Day/Year

You are requested to supply the following information, but it is not required (race and ethnicity designation--please check):

- American Indian or Alaskan Native White (not of Hispanic origin) Hispanic
 Black (not of Hispanic origin) Asian or Pacific Islander

INTERPRETER'S STATEMENT (If an interpreter is provided to assist the individual to be sterilized):

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter Signature

Month/Day/Year

Patient Identification

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File in Section 4: Authorization

