CENTRAL COAST FAMILY CARE
MEDICAL ASSOCIATES OF SANTA MARIA, INC.

Michael P. Schrager, M.D.
Richard L. Zachrich, M.D.
821 E. Chapel Street,
Suite 203
Santa Maria, CA 93454
Phone: (805) 925-5334
Fax: (805) 922-5923

John P. Okerblom, M.D.
Melinda Jezierski, M.D,PhD
5075 S. Bradley Road,
Suite 131
Santa Maria, CA 93455
Phone: (805) 938-7444
Fax: (805) 938-7422

Brian Desmond, M.D.
Laura J. Theis, M.D.
220 S Palisades Drive,
Suite 104B
Santa Maria, CA 93454
Phone: (805) 925-2521
Fax: (805) 925-8721

Mohammad A. Arain, M.D.
1505 S. Shepard Drive,
Suite 104
Santa Maria, CA 93454
Phone: (805) 928-2645
Fax: (805) 928-1995

Kamlesh M. Desai, M.D.
355 Daniel Drive,
Suite 105
Santa Maria, CA 93454
Phone: (805) 937-3368
Fax: (805) 937-3622

AUTHORIZATION FOR CONSENT TO DIAGNOSTIC AND/OR THERAPEUTIC PROCEDURE(S)

Date: _____

Patient Name: _____ DOB: _____

Proposed Operations(s) or Procedures(s): _____

Your doctor has determined that the procedure(s) listed above may be beneficial in the diagnosis or treatment of your condition.

This authorizes the procedures(s) listed above including whatever incidental procedures or services, such as anesthesia, radiology, pathology which may be advisable for your well-being. Any tissue or member severed in any procedure will be disposed of at the discretion of the pathologist.

These special diagnostic or therapeutic procedures all involve risk of complications, serious injury, or even death from both known and unknown causes. Except in cases of emergency or exceptional circumstances, these procedures are not performed unless the patient has had an opportunity to discuss them with his/her physician. Each patient has the right to consent or to refuse any proposed procedure.

YOUR SIGNATURE BELOW CONSTITUTES YOUR ACKNOWLEDGEMENT

1. That you have read and agree to the foregoing
2. That the proposed procedure(s) have been satisfactorily explain to you
3. That you hereby give your authorization and consent

Patient's Signature_____ Date: _____

Witness: _____ Print Name:_____