

**University Pain Medicine Center  
Didier Demesmin, M.D.  
Board Certified in Pain Medicine  
Board Certified Anesthesiologist**

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**Authorization For Examination/Treatment**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

I, the undersigned, a patient in this office hereby authorize Dr. \_\_\_\_\_ (and whomever he may designate as his assistants) to administer such examination/treatment as is necessary, and to perform the following therapy or procedures as are considered therapeutically necessary on the basis of findings during the said course of examination/treatment.

I hereby certify that I have read and fully understand the above authorization for examination/treatment, the reasons why the above named examination/treatment is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of examination/treatment, which were explained to me by Dr. \_\_\_\_\_

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Signed: \_\_\_\_\_

Witness: \_\_\_\_\_