

## State of Oklahoma **OKLAHOMA HEALTH CARE AUTHORITY**

## **CONSENT FORM**

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 (doctor or clinic) 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 will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) 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 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 thirty 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 (mm/dd/yyyy)  I,		
by a method called  My consent expires 180 days from that 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.		
Signature		
Date		
You are requested to supply the following information, but it is not required: (Ethnicity and Race Designation) (please check)  Ethnicity: Race (mark one or more):  Hispanic or Latino American Indian or Alaska Native  Not Hispanic or Latino Black or African American  Native Hawaiian or Other Pacific Islander  White		
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's Signature Date

## STATEMENT OF DEDSON ORTAINING CONSENT

Before (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.  I informed the individual to be sterilized that his/her consent can		
be withdrawn at any time and that he/s services or any benefits provided by Fe To the best of my knowledge and sterilized is at least 21 years old and all He/She knowingly and voluntarily requappears to understand the nature and	the will not lose any health ederal funds. d belief the individual to be ppears mentally competent. ested to be sterilized and	
Signature of person obtaining consent	Date	
Facility	/	
Addres		
PHYSICIAN'S ST	CATEMENT	
Shortly before I performed a steril individual) on (date of I explained to him/her the nature of the	lization operation upon (name of of sterilization)	
individual's signature on this consen sterilization was performed.	t form and the date the	
<ul> <li>2. This sterilization was performed le 72 hours after the date of the individ form because of the following circum and fill in information requested):</li> <li>Premature Delivery</li> <li>Individual's expected date of deliv</li> </ul>	lual's signature on this consent nstances (check applicable box	
☐ Emergency abdominal surgery (D	-	
Physician:		

Date: \_\_\_