GENERAL INFORMED CONSENT

Córdoba,.....……

PATIENT'S NAME AND LAST NAME……..

ID TYPE:..... No.:.....

Dear patient: Sanatorio Allende would like to remind you of some important considerations about the document presented below. An *informed consent* is the permission granted by a patient or their family to undergo a specific intervention, treatment, or procedure after understanding what said intervention, treatment, or procedure entails, together with its risks, benefits, limitations, and potential consequences. Therefore, we encourage you to ask any questions you may have and request any clarifications you may need regarding the diagnosis, intervention, procedure, and/or treatment recommended by the health care professional. Do not sign any document without first receiving the necessary information.

1. Dr. ……, prof. license No. ……., and their team have explained to me in clear and simple terms my health condition. Therefore, I am informed that:

☐ I require hospitalization

☐ I do not require hospitalization

2. By virtue of the foregoing, I authorize this facility and its health care team to perform complementary studies (laboratory, imaging, among others) and treatments considered standard practice and of low risk that are required for the management of my condition.
3. By virtue of the above, I request and at the same time authorize Sanatorio Allende to provide me with the relevant services during my admission, such as the provision of an operating room, nursing care, medicines, diagnostic imaging tests, laboratory and pathologic studies, nutritional support, accommodation, and any other services deemed necessary for my treatment.
4. I also understand and authorize that the clinical or surgical follow-up of my condition may be carried out by different professionals who provide services at the facility. I am aware of my right to make interconsultations with other specialists outside the facility, which I will inform the health care team of Sanatorio Allende as soon as possible.
5. I authorize the attending professional to take pictures of or digitally record the procedure for scientific, educational and academic purposes, provided that my identity is kept strictly confidential as required by Argentinian Law No. 26.529.
6. In view of the existence of security cameras within the facility, I recognize the possibility of being recorded. These images will not be disclosed to third parties, except in cases where there is just cause for disclosure.
7. I am aware that the practice of medicine is not an exact science and I recognize that although the professional has properly informed me of the desired outcome of treatment, I have not been given any guarantees.
8. I also understand that I have the right to refuse certain treatments or procedures, under my sole responsibility, after having been notified in writing of the risks involved.
9. If I have issued Advance Directives regarding my health care (decisions related to the acceptance or refusal of specific medical, preventive, or palliative treatments), I agree to inform my primary care physician in writing.
10. I authorize that, in the event that my life is in danger and I am unable to sign a specific informed consent, any attempt will be made to contact my legal representative/family to inform them of the procedures/treatments which I must undergo urgently. Such procedures/treatments may include surgery, anesthesia, transfusions, among others.
11. I acknowledge that, in accordance with the regulations of Sanatorio Allende S.A., medical practices and/or services are carried out with absolute respect for human life and dignity in all stages of its existence, following the principles of personalist bioethics.
12. I attest that I have not omitted or altered any information when providing my medical and surgical history, nor have I omitted any information about previous treatments or operations that may have been performed on me by other professionals.
13. I declare that I am allergic to: ……..
14. I also understand that I may be asked to sign a specific consent for high-risk procedures/treatments (transfusions, anesthesia, sedation, acute hemodialysis, among others), as long as my medical condition allows it and my life is not at risk.

SANATORIO ALLENDE

I, Micaela Tenaguillo Cicconi, Public Sworn Translator of English, Register No. 998, granted by the *Colegio de Traductores Públicos de la Provincia de Córdoba* (CTPPC) (Professional Association of Sworn Translators of the Province of Córdoba), do hereby certify that this a true and faithful translation into English of the document written in Spanish which I have had before me. In witness whereof, I sign and seal this translation.

MICAELA TENAGUILLO CICCONI
TRAD. PUB. NAC. DE INGLÉS
M.P. 998.

15. Dr. ……, prof. license No. , and their team have explained to me in clear and simple terms that due to my health condition I require:

- ☐ Study / Observation
- ☐ Surgery / Procedure
- ☐ Treatment

Known as:.....

Based on the diagnosis: .....

16. By virtue of the medical practice described above, I confirm that the physician (and their team with privileges and competencies) has explained to me in clear and simple terms the characteristics, objectives, possible adverse effects and complications that may occur, and the advantages, alternatives and possible outcomes of not undergoing treatment, as well as the warning signs during recovery, all of which are described in Annex I.

17. I have been explained other alternative methods for the proposed diagnostic/therapeutic technique and I accept the present one as the most appropriate in the current circumstances.

CONSENT APPROVAL

Patient's signature (13 years of age and older) (*):

Signature:……

Name (in print):……..

Patient's ID:……

Physician's signature:……

Name (in print):……

License:……..

Parents'/representative's signature (if the patient is under 18 years of age), as appropriate (*):

Signature:……...

Name (in print):……..

Patient's ID:……

Signature:……

Name (in print): ……..

Patient's ID: ……

WITHDRAWAL OF CONSENT

This document serves as a formal WITHDRAWAL of your previous consent to undergo surgery/treatment/procedure. You must sign only if you wish to withdraw your consent. If you are signing a consent for surgery/treatment/procedure, DO NOT SIGN THE WITHDRAWAL.

I, the undersigned,....., having been informed about the nature of my medical condition, the benefits, advantages, and potential risks or complications, do hereby declare I consciously and voluntarily refuse/withdraw my consent to undergo the procedure. I acknowledge that I am fully responsible for any consequences that may arise from this decision. Dated: ……

Signature and name (in print) Patient	Signature and name (in print) Legal representative	Signature and name (in print) Physician

It is hereby stated that this informed complies with the provisions of Law No. 26.529, Law No. 26.742 and their regulatory decrees, as well as Article 59 of the Argentinian Civil and Commercial Code.

(*) According to Art. 26, of the Argentinian Civil and Commercial Code, "Adolescents between the ages of thirteen and sixteen are presumed to have the capacity to decide for themselves regarding treatments that are not invasive, do not compromise their health, or pose a serious risk to their life or physical integrity. In the case of invasive treatments that compromise their health or put their integrity or life at risk, the adolescent must give their consent with the assistance of their parents. Any conflict between the adolescent and their parents should be resolved in the best interest of the adolescent, taking into account the medical opinion regarding the consequences of performing or not the medical procedure. Starting at the age of sixteen, an adolescent is considered an adult for making decisions regarding the care of their own body."
According to the Patient's Rights Argentinian Law 26.529, Article 6, as amended by Law 26.742: In the event that the patient is incapacitated or unable to provide informed consent due to their physical or mental state, consent may be given by the persons mentioned in Article 21 of Law 24.193, in accordance with the requirements and order of precedence established therein. a) The non-divorced spouse who lived with the deceased, or the person who, without being the spouse, lived with the deceased in a conjugal-type relationship for no less than THREE (3) years, in a continuous and uninterrupted manner; b) Any of the children over the age of EIGHTEEN (18) years old; c) Either of the parents; d) Any of the siblings over the age of EIGHTEEN (18) years old; e) Any of the grandchildren older than EIGHTEEN (18) years old; f) Any of the grandparents; g) Any blood relative up to and including the fourth degree; h) Any relative by affinity up to and including the second degree; i) The legal representative, guardian or curator; The relationship must be duly proven.