INFORMED CONSENT FOR BILATERAL MALE MASTECTOMY

1. I hereby request and authorize Dr. Harold M. Reed, assisted by his designated personnel to perform the urological operation entitled "Bilateral Male Mastectomy" in an effort to reduce male gynecomastia (the size of my breasts).

2. Dr. Reed has discussed his case experience with me but has not made any promise of a specific performance or guaranteed either expressly or by implication a result.

3. Post-operative swelling of some areas of the breast may last up to six weeks.

4. Patches of induration or firmness under the nipple or areola (the pigmented area around the nipple) may occur as a reaction to this procedure and usually resolves over a period of a few months.

5. If applicable, I have discussed this procedure with my sexual partner or "significant other" and have gained their approval, or after careful consideration of my situation and relationship have decided to proceed.

6. I will not sun bathe for at least 6 weeks.

7. I have abstained from smoking for 1 month prior to this procedure and will abstain for 2 months following this procedure.

8. Complications of this procedure include pain or discomfort, separation of incisional margins, black and blue bruising, and irregular contours, areas of firmness to touch, loss of nipple and areolar, and unsightly scars. I can appreciate that with any surgical procedure there may be unforeseen complications as well.

9. I will call Dr. Reed immediately if there are any concerns and keep my follow-up appointments with him.

10. The patient consents to medical photography before, during, and after treatment, and that these photographs become the property of Dr. Harold M. Reed, and may be utilized for but not limited to publication in scientific journals, or presentation in a manner related to medical practice.

11. The administration of anesthesia, should an anesthetist or anesthesiologist be used, is an independent function and any questions regarding anesthetic management should be addressed directly to the anesthetist. A remote complication of general anesthesia is inadequate intubation, and a remote complication of local anesthesia with IV sedation is inadequate pain control.

12. The maintenance of personal hygiene is important in preventing post-op infection.

13. I am aware that Dr. Harold Reed has elected under the provisions of Florida State law not to carry professional liability insurance.

14. I am aware following this procedure I will need to wear a constriction garment vest to reduce swelling and abdominal binder (if applicable) post-operatively.

I have read and signed the above consent in the presence of a witness whose signature appears below, after I have had an opportunity to question Dr. Reed regarding any unfamiliar medical terminology.

PATIENT:_____DATE:_____

WITNESS:_____

I have personally discussed with the patient the above described proposed surgery, its risks and potential complications, as well as the alternatives available.

FOR EMERGENCIES: Back line 1-305-865-2003, cell 1-828-606-4504, vacation home 1-828-891-1087.

HAROLD M. REED, M.D.

(conmastectomy)