

Acct. # \_\_\_\_\_

I hereby authorize

Stephen J. Kominsky, DPM, FACFAS

to surgically operate on my \_\_\_\_\_

To the best of my knowledge, I have not had any allergic reactions to any drug  
except: \_\_\_\_\_

Date: \_\_\_\_\_ 20\_\_\_\_\_

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

Signature: \_\_\_\_\_

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