Driver Information

I understand and agree that, at the time the patient has met Andover Surgery Center's medical criteria to leave the center, I will have a responsible adult present to take me (the patient) home. I release Andover Surgery Center from any responsibility for events in violation of this agreement.

Driver Name: _____will be driving the patient home after discharged

from the center. **Relationship to patient:** _____. (Example: Spouse, Sibling)

☐ Driver will remain at the center during surgical procedure.

☐ Driver will be leaving the facility.

Driver phone number: _____

I certify that I have read the foregoing and that I am either the patient, parent, legal guardian or am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____

Signature of Patient, Parent, Legal Guardian, Representative **Date**

_____

Relationship to Patient **Date**

_____

Signature of Witness **Date**

_____ **AM/PM**

Time

PATIENT INFORMATION

ANDOVER SURGERY CENTER

ANDOVER AMBULATORY SURGERY CENTER
1124 West 21st Street, Suite 100
Andover, KS 67002
December 2019

MR #: **FIN#:**
ADT: / / **DOB:** / /
DR: