

**INFORMED CONSENT TO MEDICAL PROCEDURE  
OR OPERATION BY PHYSICIAN WITHOUT  
MEDICAL PROFESSIONAL LIABILITY INSURANCE**

1. I, \_\_\_\_\_ am a patient of  
(Print patient's first and last name)

Dr. \_\_\_\_\_;  
(Print physician's first and last name)

2. I am having \_\_\_\_\_  
(Identify name of operation or medical procedure)

performed on \_\_\_\_\_ at \_\_\_\_\_ a.m. / p.m.;  
(Date) (Time)

3. Dr. \_\_\_\_\_ has discussed with me, and offered as information for me to consider, that Medical Professional Liability Insurance is not maintained or has lapsed; and

4. I consent to Dr. \_\_\_\_\_ performing the aforementioned operation or medical procedure.

\_\_\_\_\_  
**Patient's Signature** Date: \_\_\_\_\_

\_\_\_\_\_  
**Physician's Signature** Date: \_\_\_\_\_

*This Informed Consent form must be signed by the patient and the physician and retained in the patient's chart.*

The language in this document was drafted and approved by the Maryland Board of Physicians in compliance with Maryland Code Annotated, Health Occupations Article §14-508 (effective date October 1, 2017). Alteration of the language in this document may result in non-compliance with the law.