INFORMED CONSENT FOR LABIAPLASTY

1. I hereby request and authorize Dr. Harold M. Reed, M.D. who may be assisted by his designated urological associates and surgical technicians, to perform the urological operation entitled "Labiaplasty" in an effort to reduce and restore a more delicate appearance to my labia which may include clitoral hood, labia majora and labia majora.

2. Dr. Reed has discussed his case experience with me but has not made any promise of a specific performance, or guaranteed whether expressed or implied, a specific result.

3. Post-operative swelling of the labia, bruising and some **Spotting may be noted and may last up to six weeks** Minimal areas of numbness may occur lasting for a few weeks.

4. Intended area of incisions have been shown to me during my examination and medical illustrations.

5. I recognize that there are inherent risks in all surgical procedures and can appreciate the possibility of side effects and complications stemming both from the procedure and recovery therefrom including but not limited to hematoma which is a localized collection of blood or blood clot, infections, neurological numbness stemming from possible neurological injury although I know Dr. Reed will take every precaution.

6. I give permission for genital photography before, during, and after the procedure, and agree that these photographs shall be property of Dr. Harold M. Reed, and may be utilized for, but not limited to: publication in scientific journals, or presented for scientific reasons or in a manner directly related to the practice of medicine.

7. I will call Dr. Reed immediately if there are any concerns and keep my appointments with him.

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8. 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. I and my partner are aware that there will be a period of sexual abstinence, and can appreciate the emotional consequences of this hiatus, as well as any unanticipated complications stemming from this procedure. Presently, I do not have any significant emotional disorder.

9. I understand the maintenance of personal hygiene, especially genital cleanliness is extremely important in preventing post-operative infection.

10. I have abstained from smoking for 2 weeks prior to this procedure and will abstain for 2 months following this procedure.

11. I understand that I am to be in a convalescent status with a generous amount of bed rest for 2 days after surgery. For one month after surgery I will not engage in any stressful physical activity including excessive bending, lifting or participation in any sports. I will abstain from sexual relations for five weeks following surgery.

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

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.

Dr. Reed has a proprietary interest in this Centre. You may wish to consider alternative sites for evaluation and treatment.

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.

Harold M. Reed, M.D.