DR. VICTOR URZOLA
PLASTIC AND RECONSTRUCTIVE SURGERY
LASER CENTER

I _____, Id number _____In full mental capacity and with full knowledge and understanding of the possible complications that can occur during or after surgical procedures (that I have asked you to do)authorize Dr. Urzola and his surgical team to do the following procedure (s):

_____

_____

Dr. Urzola and his team have carefully explained the implications, limitations and possible complications of the above procedure.

Having read and understood the consent forsurgery / procedure or treatment; I request and authorize the procedure mentioned above.

_____
Patient or Person Authorized to Sign for Patient

Date _____

Witness _____