



INFORMED-CONSENT- PHOTO DISCLOSURE

Patient	
Id Number	
Date of birth	Month Day Year
E-mail	
Phone Number	
Procedimiento	Photo Disclosure

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Initials **PATIENT**

Initials **Dr. URZOLA**

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PATIENT

DR. URZOLA

SIGNATURE

SIGNATURE

NAME

NAME: Victor Javier Urzola Herrera

ID NUMBER

ID NUMBER: 109660360

Initials **PATIENT**

Initials **Dr. URZOLA**