

**Patient's Information**

Surname:	First Name:
Father's Name:	Date of Birth:

**Consent Statement**

The signatory, having full consciousness and total understanding of the meaning and content of the explanation I have been given about the necessity, the purpose, the nature and the possible complications or undesirable effects of the, recommended by the doctors, diagnostic and therapeutic action and the procedure of anaesthesia to which I will undergo:

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I hereby confirm that I give my unconditional consent to the attending doctor:

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1. To proceed with the above diagnostic or therapeutic action and every intervention that will be deemed necessary during the procedure.
2. To administer, if needed, any kind of anesthesia or mild sedation.
3. To run any sort of medical examinations required to the tissues that will be removed.
4. To photograph or film the procedure for educational or research purposes and I consent for the material to be shown to students or other doctors, only for educational reasons.
5. To take pictures that will be accompanied by my first name and surname before and after the procedure for the clinic's purposes (these include but are not limited to - the clinic's archive, publication of a successful operation result)

Date

Client's Signature