

GENERAL CONSENT FORM



I, (Name) _____

of, (Address) _____

consent to the operation of _____

(and medication or anaesthetic, if need be) being performed upon myself.

I fully understand the nature of the procedure. The possible complications have been fully explained to me, such as redness, swelling, lumps, peeling, scabbing, infection, scars, temporary or permanent pigmentation changes, pain, the need for further treatment, damage to other regions and other severe or unexpected side effects such as death. I release Dr Murray and all staff from medicolegal liability.

Signed: _____ Date: _____

Witnessed: _____ Date: _____

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