INFORMED CONSENT

Patient name Age I.D.
Physician name Department

PHYSICIAN'S STATEMENT:

I confirm that I have explained the proposed treatment and its possible side effects and associated. I also explained to the patient and / or family, the purpose of such treatment and treatment options available in a simple way.

Physician name: Sign:

PATIENT STATEMENT:

I declare that my doctor has explained the conditions of my health condition, the proposed treatment and / or procedure, the alternatives, the risks, the complications and I have understood and decided to authorize the procedure (s) indicated as well as the application of any other treatment during or after the procedure, which is necessary to resolve the possible complications that may arise and which will only be performed if necessary, in my best interest and justified for medical reasons.

ESTIMATED PATIENT AND / OR FAMILY MEMBER:

Read carefully the contents of this form. If there is something that you do not understand about what was explained by your doctor, or if you want more information, ask for it.

Make sure that all the information presented in this form is correct. If you are, and you feel satisfied with the explanation given by your doctor, sign the form.

Patient name:
Card ID/Passport:
Sign:
Date:

Witness name:
Card ID/Passport:
Sign: