

Mountain State Dermatology Laser Consent Form

Date:

Patient:

DOB:

I authorize Dr. Norton to perform the following therapy on me:

I certify that I have been fully informed by Dr.Norton of the risks, possible complications and alternative treatments of this procedure. I have been informed of the following:

complete clearing may not be possible.

multiple treatments may be required and

Signed:

Date:

Witness:

Date: