[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Surgeon's Name]
[Surgeon's Address]
[City, State, Zip Code]

Dear [Surgeon's Name],

Subject: Consent for Uvula Surgery

I, [Patient's Full Name], born on [Patient's Date of Birth], hereby give my consent for the surgical procedure known as uvula surgery, which I understand aims to [briefly explain the purpose of the surgery, e.g., "correct obstructive sleep apnea," "reduce snoring," or "treat uvulitis"].

I confirm that:

1. I have been informed about the nature and purpose of the surgery.
2. I have discussed with my surgeon the risks and benefits associated with the procedure.
3. I understand the potential complications and recovery process.
4. I have had the opportunity to ask questions and have received satisfactory answers.
5. I am aware that sedation or anesthesia will be used during the surgery.

I understand that I have the right to withdraw my consent at any time before the procedure is performed.

By signing below, I consent to the uvula surgery and acknowledge that I have read and understood the information provided.

Patient's Signature: _____
Date: _____
Surgeon's Signature: _____
Date: _____
Witness Signature: _____
Date: _____

Thank you for your care.

Sincerely,
[Your Name]