Dermatology *Partners*, Inc.

PATIENT CONSENT FOR PROCEDURE (MINOR SURGERY)

PATIENT NAME: _____ DATE: _____

PROCEDURE: _____

I understand that the nature of the procedure that has been recommended.

Possible Complications:

- Infection
- Bleeding
- Allergic Reaction
- Incomplete excision (possibly requiring additional excision)
- Scarring

I hereby give my voluntary consent to the procedure described above.

I give my permission for a message to be left for me explaining the result of the biopsy or biopsies.

(Initials) _____ Telephone Number: _____

PATIENT SIGNATURE: _____ DATE: _____

PROVIDER SIGNATURE: _____ DATE: _____