KNOTT STREET
DERMATOLOGY

SURGERY CONSENT FORM

I, _____ (Patient Name) give permission to _____ (Provider Name)

to perform surgery to remove _____ (Lesion Type)

on_____ (Location).

The surgery is performed by injecting the skin with anesthetics (medications to numb the skin). The visible lesion is removed. A margin of normal skin may also be removed. The method of repair will depend on the size and location of the lesion. Typically, sutures (stitches) will be placed to close the area and will need to be removed 1-2 weeks after surgery, depending on the surgery site. After the area has healed, there will be a visible scar.

It is important to realize that no surgery has a 100% success rate and the lesion may recur even after surgery. Possible risks and complications of this procedure are pain, bleeding, bruising, and infection. Minor or serious reactions can occur with the use of anesthetics. Nerves controlling muscle movement, sensation, or other functions may be damaged and this damage may be permanent.

I have read the above information and have discussed with my doctor the nature of the proposed surgery, the therapeutic alternatives, and the potential complications of the procedure. I understand that no guarantee is made regarding a specific outcome of the surgery. I request that surgery be performed.

I authorize and consent to the taking of photographs before, during, and after surgery, and at follow-up visits. I understand that photographs are primarily for medical documentation of my surgery. They may also be used for medical education and publication in medical journals. I understand that no identifiable photograph of me will be published without my permission.

PATIENT PRINTED NAME	PATIENT (OR GUARDIAN) SIGNATURE	DATE
PROVIDER NAME	PROVIDER SIGNATURE	DATE

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