CONSENT FOR CUTANEOUS BIOPSY- SHAVE

PATIENT:_____ AGE:_____ DATE:_____ TIME:_____

I hereby authorize Dr. _____ to perform upon me the following surgical procedure: Shave biopsy of skin. This is a minimally invasive surgical procedure whereby a superficial layer of skin is removed under local anesthesia for laboratory analysis. I understand that surgical closure of the biopsy site is not typically indicated; however, may be deemed necessary at the discretion of the doctor. Unlikely, but potential, complications of this procedure include local bleeding, infection, or prolonged pain.

I consent to the administration of local anesthesia under the direction of the above named physician as he deems advisable.

The nature and purpose of this biopsy, the risks/benefits of leaving the process undiagnosed, and the possibility of complications have been fully explained to me by the above named doctor. I acknowledge that no guarantee or assurance has been made to me regarding the results that will be obtained from this procedure.

I certify that I have read and fully understand the above consent to biopsy and the associated explanations given by the above listed doctor.

SIGNATURE OF
PATIENT:_____DATE_____

The foregoing consent was read, discussed and signed in my presence and in my opinion; the person(s) so signing did so freely with full knowledge and understanding.

SIGNATURE OF
WITNESS:_____DATE_____