TruDerm

Adult & Pediatric Dermatology & Cosmetic Center

CONSENT FOR THE GENERAL MINOR PROCEDURES NECESSARY TO THE PRACTICE OF DERMATOLOGY

AUTHORIZATION FOR MEDICAL TREATMENT, ADMINISTRATION OF LOCAL ANESTHESIA AND THE PERFORMANCE OF MINOR SURGERY AND/OR PROCEDURES

1. **I authorize the use and administration of drugs, anesthetics, and other treatment, including the performance of a skin biopsy, the use of cryosurgery with liquid nitrogen, and the injection of cortisone, should any of these be deemed advisable or necessary for diagnostics or investigational purposes by the provider(s) at Truderm Dermatology.**

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2. **I consent to the examination for diagnostic, investigational purposes, and disposal by authorities of Truderm or its designates herein, of any tissue or parts which may be removed.**

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3. **I understand that the skin biopsy involves removal of a piece of skin and that such removal may result in a permanent scar or discoloration of the skin at the site of the biopsy. I further understand that more than one biopsy may occur during this visit.**

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4. **I understand that all specimens removed are sent for dermatopathologic analysis and that the charges for dermatopathology will be billed to my insurance. However, I understand that in certain cases, I may be responsible for a portion or all of the charges.**

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5. **I understand that the destruction with liquid nitrogen of precancerous lesions, which are also known as actinic keratosis or solar keratosis, as well as warts or Molluscum may be deemed necessary by the provider(s).**

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6. **I understand that the injection of triamcinolone (cortisone) for the treatment of scars, cysts, acne, and inflammatory conditions like psoriasis, atopic dermatitis, and alopecia areata, may be deemed necessary, advisable or desirable by the provider(s).**

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7. **I understand that any of the above procedures may have some unwanted effects, which include, but are not limited to permanent scarring, permanent discoloration of the skin at the site of treatment, atrophy, infection, bleeding or nerve damage resulting in temporary or permanent numbness or function of certain muscles (paralysis).**

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I CERTIFY THAT I HAVE READ, FULLY UNDERSTAND AND RECVIEVED A COPY OF THE ABOVE CONSENT AND THAT I HAVE RECEIVED CLEAR EXPLAINATIONS REGURADING THE PROVIDED INFORMATION.

Signature of patient_____ **Date:** _____

If patient is under age 18 or unable to authorize consent:

Signature of parent or legal guardian _____ **Date:** _____