Dermatology, Cosmetic Dermatology & Lasers

3655 Lomita Blvd #215 Torrance, CA 90505
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Tel: 310.378.8885

Consent to Surgery or Special Procedure

I hereby authorize and direct my provider, Dr. Hala Koudsi to perform an operation or special procedure upon me and to any other diagnostic and therapeutic procedure that their judgment may dictate to be advisable to my well being.

I understand and agree that if the practitioner named above is unable to perform or complete the task, a substitute practitioner(s), including possible alternative methods of treatment, where applicable. I understand that such operation(s) or procedures (s) may involve calculated risks or complications, injury or even life threatening, from both, known and unknown causes. I understand that in the event of unforeseen circumstances, additional procedures may need to be performed. Where applicable; the physician has also discussed the risks, benefits and alternatives. No warranty or guarantee has been made as to result or cure, and I fully understand that if I have any questions or concerns, I have the right to discuss them with my physician before agreeing to the operations or procedures. I recognize that this form is not intended to be a substitute for the explanations which have been provided by my physician, Nurse Practitioner or Physician Assistant.

Having received this explanation, I consent to the performance of the following stated operation(s) or special procedures.

Skin Biopsy: ☐ Shave
☐ Punch
☐ Horizontal Excision
☐ Excision

Others ☐

I hereby authorize and direct the physicians, surgeons, NP's and PA's of the medical staff of this medical office to provide such additional services for me as they may deem reasonable and necessary including, but not limited to the administration and maintenance of anesthesia. The person or persons performing other specialized professional services, such as pathology and the like, are not the agents, servants or employees of the above named medical office or of the above named physician, surgeon, NP and PA, but are independent contractors performing specialized services on our behalf.

I hereby authorize our office pathologist to use discretion in the disposal of any tissue removed during the procedure set forth above.

SIGNATURE OF THE PATIENT/PATIENT'S REPRESENTATIVE reason patient did not sign

X _____ Date _____ Time _____
YOUR SIGNATURE

Relationship If Other Than Patient _____

WITNESS to above signature PRINT name _____ SIGNATURE _____

TRANSACTION (if necessary) - I have accurately and completely read the foregoing document to the signature identified below in the patient's representative's primary language. He/she understood all terms and conditions and acknowledged his/her agreement by signing this document in my presence. Primary language if not English.

TRANSLATOR SIGNATURE _____

VERIFICATION of informed consent form: I have informed this patient of the risks, benefits, potential complications, and alternative treatments, including list of the informed consent

PROVIDER SIGNATURE _____ Date _____ Time _____