INFORMED CONSENT FOR PROCEDURES

My signature on this form authorizes the Doctors and Physician Assistants of Orange Dermatology Associates, P.C. to perform procedures on me that they feel are necessary for my well being, including, but not limited to injections, freezing with liquid nitrogen (cryosurgery), electrodesiccation, biopsy and excisions. Before any procedure is done, I will be informed, to my satisfaction why the procedure is necessary. I will be told what the procedure involves and what risk there is to my health, if any, if the condition were to remain undiagnosed or untreated.

I understand the risks inherent to the performance of any surgical procedure such as loss of blood, infection, reaction to anesthesia, the formation of thick or otherwise objectionable scars, skin color changes, and possible recurrence and I realize that such, or any, natural complications may result from the surgical procedure.

I give my permission to have any tissue(s) removed during the procedure be sent for histologic examination by a pathologist.

_____

Signature of patient or patient's legal guardian Signifying informed consent — Date

_____

Witness — Date

DATE	PROCEDURE	SIGNATURE