TEXAS DERMATOLOGY CENTER, DR. MARY EVERS, D.O.

Informed Consent For Minor Surgery

Patient: _____ Date of Birth: ___/___/___

Today's Date: ___/___/___ Time: _____

My signature on this form authorizes Dr.Evers to perform the following procedure:

_____
_____
_____
_____

- I have been informed and I understand the nature of the procedure and why it is necessary.
- I have been informed and I understand the risks inherent to the performance of any surgical procedure such as loss of blood, infection, reaction to anesthesia, numbness and/or lack of sensation, and the formation of thick or otherwise objectionable scars.
- I realize that these, or other 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.
- I realize the office will attempt to notify me of the pathology results, but it is ultimately my responsibility to follow-up on the biopsy results.

_____ ___/___/___
Signature of patient or patient's legal guardian signifying informed consent Date

_____ ___/___/___

Witness Date