



**CARSON DERMATOLOGY
SKIN CANCER CENTER**

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**AUTHORIZATION FOR CONSENT TO SURGERY OR SPECIAL DIAGNOSTIC
OR THERAPEUTIC PROCEDURES**

Patient's Name _____ Date _____

Proposed Operation or Procedure: _____

I hereby authorize _____ to perform the operation or procedure listed above, including the incidental procedures and services that develop directly from the above. In addition, I hereby acknowledge that:

1. The nature of my ailment or condition, the indications and necessity, character and surgical importance of the operation proposed, therapeutic options and alternatives and the reason for the recommendation of the above particular operation, and probable consequences or results and potential risks of the above operation have all been discussed with me, and that the specific effects of the operation in my situation, have been reviewed.

2. I am fully aware that surgical operations and therapeutic procedures all involve potential risks or complications from both known and unknown causes. I am aware that all operations carry the risk of infection, bleeding or hemorrhage and some degrees or type of scar formation. I am aware that, if I desire, other potential complications in general and/or significant potential complications of the particular procedure above, can be reviewed with me:

3. I am aware that the practice of medicine and surgery is not an exact science and no guarantees have been made to me concerning the proposed operation or procedure or concerning the result.

MY SIGNATURE BELOW CONSTITUTES MY ACKNOWLEDGEMENT (1) THAT I HAVE READ AND AGREED TO THE FOREGOING, (2) THAT I HAVE ALL OF THE INFORMATION THAT I DESIRE, AND (3) THAT I HEREBY GIVE MY AUTHORIZATION AND CONSENT FOR PHOTOGRAPHS.

Witness Patient's Signature

(If the patient is unable to sign or is a minor, complete the following:) (Patient is a minor (____ years of age) or unable to sign because: _____)

WITNESS CLOSEST RELATIVE OR LEGAL GUARDIAN