EXCISION CONSENT

1. I do authorize the use of, and the administration of such drugs, anesthetics, and other treatments and the performance of such operations and other procedures as may be deemed advisable, desirable or necessary for surgical repair by your Medical Provider.

2. I further consent to the examination for diagnostic, investigational purposes, and disposal by authorities or the above-named medical facility of any tissue or parts which may be removed in the process.

3. I understand that this procedure may have some unwanted effects, which include but are not limited to, permanent scarring, discoloration of the skin, infection, bleeding or, nerve damage resulting in temporary or permanent numbness or temporary or permanent loss of function of certain muscles (paralysis).

4. I recognize the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees or assurances have been made to me concerning the results of such.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT AND THE EXPLANATIONS CONCERNING THE ABOVE ITEMS WERE MADE TO ME.

Patient: _____Date Of Birth:_____

Patient or Responsible Party Signature:_____ Date:_____

Printed Name of Responsible Party:_____ Capacity:_____

1673 Gezon Parkway SW Wyoming, MI 49519
Phone - 616-243-DERM (3376) Fax – 616-243-3377