Lesion Excision

I hereby authorize Dr. Stratis and/or Gayner and such assistants as may be selected to perform the following procedure or treatment:

Lesion Excision/Shave

I recognize that during the course of the operation and medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than above. I, therefore, authorize the above named physician and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgement necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun.

I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involves risk and the possibility of complications, injury, and sometimes death.

I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

I understand that there will be bleeding, scarring, a risk of infection, and discomfort associated with this procedure. Additional treatment may be required to complete my care.

I understand the purpose of the treatment and that the treatment has been decided upon jointly by me and Dr. Stratis and/ or Dr. Gayner after consideration of the options available to me.

I consent to the disposal of any tissue, medical devices or body parts which may be removed.

I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical-device registration, if applicable.

The Following has been explained to me in a way that I understand:

A: The above treatment or procedure to be undertaken
B: There may be alternative procedures or methods of treatment
C: there are risks to the procedure or treatment proposed

I consent to the treatment or procedure and the above listed items. I am satisfied with the explanation