New Jersey Dermatology and Aesthetics Center

T (732) 702-1212

**AUTHORIZATION FOR MEDICAL TREATMENT, ADMINISTRATION OF LOCAL ANESTHESIA AND THE PERFORMANCE OF MINOR SURGERY AND/OR PROCEDURES**

AUTHORIZATION FOR MEDICAL TREATMENT, ADMINISTRATION OF LOCAL ANESTHESIA AND THE PERFORMANCE OF MINOR SURGERY AND/OR PROCEDURES

I do hereby authorize the use of and the administration of such drugs, anesthetics, and other treatments, including the performance of a skin biopsy, the use of cryosurgery with liquid nitrogen, and the injection of intralesional kenalog (cortisone), should any of these be deemed advisable, desirable, or necessary for diagnostic, therapeutic, or investigational purposes by Dr. Husain, or by any physician, physician assistant or appropriately trained and/or licensed health care personnel on the staff of New Jersey Dermatology & Aesthetics Center, for or upon me or my minor child. I further consent to the examination for diagnostic, investigational purposes, and disposal by authorities of the above named medical facility or its designees herein, of any tissue or parts which may be removed.

BIOPSY (if necessary):

* A biopsy is a surgical procedure used to obtain a sample of tissue for microscopic examination to aid the physician in diagnosis. The entire lesion may not be removed in this procedure. Further medical or surgical treatment may be needed when the diagnosis is made.
* I understand that a biopsy requires obtaining a sample of tissue and is a surgical procedure. As in any surgical procedure, there are certain inherent risks including bleeding, post-operative pain, infection, reactions to sutures, anesthetics or topical antibiotics, and scarring. Although all reasonable efforts will be made to minimize the possibility of these potential complications, no guarantees can be made since many factors beyond the control of the physician (such as the degree of sun damage or patient compliance with postoperative instructions) affect ultimate healing.
* The tissue obtained in this biopsy procedure will be examined by a pathologist. I understand that I may receive a separate bill from the pathologist or laboratory for this microscopic examination.

LIQUID NITROGEN (if necessary):

* I understand that the destruction with liquid nitrogen of precancerous lesions, which are also known as actinic keratoses or solar keratoses, may be deemed necessary by Dr. Husain or a member of the medical staff of New Jersey Dermatology & Aesthetics Center, to decrease the risk that these lesions evolve into Squamous Cell Carcinomas.
* I understand that the destruction by liquid nitrogen of warts or molluscum may be advised, but these types of lesions are not cancerous and do not necessarily have to be treated. I recognize that because they may be contagious, they should be treated. Should Dr. Husain, or a member of the medical staff of New Jersey Dermatology & Aesthetics Center, recommend destruction of these lesion by liquid nitrogen, I consent based on that advice. I am aware that these lesions may require more than a single treatment.
* I understand that this procedure has possible risks and complications that include, but are not limited to pain, blister, infection, bleeding, hematoma (bruising), prolonged or poor wound healing, scar and keloid formation, and pigmentary changes (dark or white marks).

KENALOG INJECTION (if necessary):

* I understand that the injection of triamcinolone (cortisone) for the treatment of scars, cysts, acne, and inflammatory conditions like psoriasis, atopic dermatitis, and alopecia areata, may be deemed necessary, advisable or desirable by Dr. Husain, or a member of the medical staff of New Jersey Dermatology & Aesthetics Center.

I understand that any of the above procedures may have some unwanted effects, which include, but are not limited to permanent scarring, permanent discoloration of the skin at the site of treatment, atrophy (thinning or depression of the skin), infection, bleeding, nerve damage resulting in temporary or permanent numbness or temporary or permanent loss of function of certain muscles (paralysis).

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 procedures.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND.

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Patient or Legal Guardian Date:

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