Northwell Health Physician Partners | Westchester Health

DERMATOLOGY CONSENT FOR MINOR SURGICAL PROCEDURE

Patient's Name _____ Date of Birth: _____

Parent/Guardian_____

Address_____

I hereby grant, Rhonda Berkowitz, M.D. the authority to provide the surgical procedure deemed medically necessary for my dermatologic care: _____ _____. The procedure includes the administration of local anesthesia

I fully understand and accept the potential risks associated with this treatment, including but not limited to, scarring, infection and recurrence. All related questions have been answered to my satisfaction.

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date