DSA DERMATOLOGY SAN ANTONIO

Diplomats of the American Board of Dermatology
General, Surgical and Cosmetic Dermatology

Shavano Commons Business Park **Helotes Country Village** **Westover Hills**

Consents

Dermatology Consent:

☐ I voluntary give my consent for treatment and also my consent to any procedure that my provider performs in the dermatology clinic and deems necessary for my condition, which include but are not limited to: cryosurgery (freezing of skin lesions with liquid nitrogen), incision and drainage of abscesses and cysts, removal of skin tags, shave biopsy and punch biopsy of skin lesions and rashes, debridement of wounds, injections of skin lesions, cauterizations of skin lesions, surgery / electro cautery.

I understand that my provider will discuss in detail any procedure he/she plans to perform, answer all questions relating to the procedure and obtain oral informed consent in the exam room.

Photo Consent:

☐ I consent to medical or cosmetic photographs be taken of me by DSA and/or staff. I understand that it is possible that someone may recognize me. Refusal to consent to photographs will in no way affect the medical care I will receive. If I wish to withdraw my consent in the future, I may do so with a written request.

I authorize the use of these images:

- For demonstration purposes including office photo album ☐ Yes ☐ No
- On our website ☐ Yes ☐ No
- Print advertising and/or professional journals ☐ Yes ☐ No

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand. I may revoke this consent at any time by submitting a written request.

Patient Name: _____ DOB: _____ / _____ / _____
(Patient /Legal Guardian)

Signature: _____Date: _____ / _____ / _____
(*Parent/Legal Guardian*)