

MOHS MICROGRAPHIC SURGERY CONSENT

I, _____, hereby authorize Dr. Matthew Quan to perform Mohs Micrographic Surgery on my skin cancer(s). This includes, but is not limited to, laboratory and biological tests and the administration of anesthetics, which are deemed appropriate and necessary by Dr. Quan.

I have been informed of how the procedure will be performed and the alternative procedures that are available to me. I have also been informed of the possible risks and complications of surgery including, but not limited to:

- Scarring
- Pigmentation
- Nerve Damage (both motor and sensory)
- Infection
- Medication Reaction
- Bleeding
- Recurrence of Skin Cancer

I am aware that these complications may occur in this procedure. I am also aware that the type of, or the extent of, complications that may occur cannot be determined by the physician prior to the surgery.

I also give Dr. Quan permission to take photographs of my skin lesion(s) and wound(s) and/or any tissue removed before, during or immediately after the surgery as well as on subsequent office visits. I understand that these photographs may be used for educational purposes and may be published in professional journals or medical books. However, in such an event, I will not be identified by name. Furthermore, I expect no compensation for these photographs and waive all rights or any claims for payment or royalties. I also release Dr. Quan and The Center for Dermatology, Cosmetic and Laser Surgery from liability in connection with the use of such photographs.

I also hereby authorize and direct Dr. Quan to retain and obtain complete custody and control of all medical records, tissue slide, photographs, and medical charts pertaining to any medical and surgical treatment of skin cancer(s) received by me from my physician or medical personnel within the past seven years.

This authorization is given for the purpose of facilitating Dr. Quan in his care and treatment of me as his patient. This shall supersede all previous authorizations or agreements executed by me.

I agree that this consent form will remain valid for any further Mohs surgeries that I may have at The Center for Dermatology, Cosmetic, and Laser Surgery.

Patient (or Guardian)

Date

Witness

Date