



# Informed Patient Consent

My signature on this form authorizes Dr. \_\_\_\_\_ or \_\_\_\_\_ PA/NP (Physician Assistant / Nurse Practitioner) to perform the following procedure(s):

- |                                       |  |  |  |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Shave Biopsy | <input type="checkbox"/> Cosmetic Shave Removal          | <input type="checkbox"/> Electrodesiccation    | <input type="checkbox"/> Cosmetic Punch Excision |
| <input type="checkbox"/> Punch Biopsy | <input type="checkbox"/> Cosmetic Skin Tag Removal       | <input type="checkbox"/> Incision and Drainage | <input type="checkbox"/> Intramuscular Steroids  |
| <input type="checkbox"/> Cryotherapy  | <input type="checkbox"/> Intralesional Steroid Injection | <input type="checkbox"/> Canthacur PS          | <input type="checkbox"/> Other _____             |

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