INFORMED CONSENT FOR LASER TREATMENT PROCEDURES OF SKIN

I hereby authorize ***Partners in Health/Olina E. Harwer, M.D.*** and such assistants as may be selected to perform the following procedure or treatment: ***Laser Skin Treatments***.

I recognize that during the course of the operation and medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than those above. I, therefore, authorize the above physicians and assistants, or their designees, to perform such other procedures that are in the exercise of his/her professional judgment, necessary and desirable to achieve the result I seek. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun. I consent to the administration of such anesthetics considered necessary and advisable. I understand that all forms of anesthesia involve risk and the possibility of complications, injury and, sometimes, death.

I acknowledge that no guarantee has been given by anyone, as to the results that may be obtained. I consent to the photographing, video recording or televising of the operation(s) or procedure(s) to be performed, including appropriate portions of my body for medical, scientific or educational purposes, provided my identity is not revealed by the pictures. If used for education or advertising, I will not be identified by name and my name may not be used without my written authorization. For purposes of advancing medical education, I consent to the admittance of observers to the operating/ procedure room.

I consent to the disposal of any tissue, medical devices or body parts which may be removed.

I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical-device registration, if applicable.

It has been explained to me in a way that I understand:

1. the above treatment or procedure to be undertaken.
2. there may be alternative procedures or methods of treatment.
3. there are risks to the procedure or treatment proposed.

I understand the above information and I consent to the treatment or procedure and the above listed items. Alternatives to this procedure have been discussed and I am satisfied with the explanation and answers to any questions I may have, and I knowingly accept any risks described herein. This consent will be effective for the duration of laser treatments needed to treat the condition(s) named above.

I have explained the above information: ______________________________ MD/agent

Patient or Authorized Patient Representative: ______________________________

Please Print

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Signature of Patient or Authorized Patient Representative

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Date

____
Witness

____
Date

☐ I hereby authorize my photograph(s) to be used in advertising materials by Partners In Health/Olina E. Harwer, M.D.
Signature of Patient/Authorized Patient Representative:______________________ Date:__________
Signature of Witness:______________________ Date:__________