HELEN SHIM, M.D., PLLC
DERMATOLOGY/DERMATOPATHOLOGY

BIOPSY INFORMED CONSENT

Patient Name_____ DOB: _____

A skin biopsy involves removal of a small piece of skin under local anesthesia. The piece of skin is then processed and examined under a microscope or is tested in some other fashion to obtain diagnostic information. Possible complications include bleeding, scarring, infection, nerve damage, recurrence, or the need for further procedures. I have been informed, to my satisfaction, regarding the nature of the procedure and why it is being performed.

I understand that a biopsy does not guarantee complete removal of a lesion or that a diagnosis will be obtained. In a small percentage of cases, even with the biopsy information, a diagnosis may not be arrived at and another biopsy or special stains may have to be done.

I also realize and understand that if there are any costs related to the biopsy, pathology, cultures, or other lab work that my insurance carrier does not cover, that I am responsible for those costs.

I give consent for any lab/pathology results to be called to the following phone number(s):

Primary Phone Number _____ Secondary Phone Number _____

I give consent for a message to be left at the same phone number(s).

Yes_____ No_____

Permission is given to release information to:

_____ _____
(Name of person) (Relationship to patient)

I hereby consent to a biopsy when necessary by Dr. Helen Shim, M.D.

Patient Signature_____ **Date**_____

Guardian Name & Signature (if a minor) _____ Date_____

Witness Name & Signature_____ Date_____

Physician Name & Signature_____ Date_____

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