



Compassion Care Clinic  
2269 Wilma Rudolph Blvd Ste 106  
Clarksville, TN 37040  
Phone: (931) 542-9010

**PATIENT INFORMED CONSENT AND RELEASE FOR SKIN LESION REMOVAL**

**PATIENT**

**DATE OF BIRTH**

**ADDRESS**

**PHONE**

I Hereby authorize and direct Stacey Michelin, NP to perform Skin Lesion (Mole) removal procedures on me. There are various benefits to this procedure, including:

- Removing protruding Skin Lesions that get in the way of shaving
- Reducing skin irritation and infection that can occur when certain Skin Lesions rub against clothing and/or jewelry.
- Achieving smoother, clearer skin.
- Enhancing appearance and improving self-esteem.
- This Skin Lesion removal procedure may be viewed as COSMETIC.

The following points have been discussed with me:

- The potential benefits of the proposed procedure.
- The possible alternative procedures.
- The probability of success.
- The reasonably anticipated consequences if the procedure is not performed.
- The most likely possible complications/risks involved with the proposed procedure and subsequent healing period, including infection, scarring and skin discoloration.

I am aware of the following possible experience/risks with Skin Lesions being removed:

- DISCOMFORT - Some discomfort may be experienced during and after the procedure.
- INFECTION - Skin infection is a possibility although rare, whenever a skin procedure is performed.
- PIGMENT CHANGES (Skin Color) - During the healing process, there is a possibility that the treated area can become either lighter or darker in color compared to the surrounding skin. This is usually temporary, but on rare occasion, it may be permanent.
- SCARRING - Scarring is a rare occurrence, but is a possibility when the skin's surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all posttreatment instructions carefully.



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### ACKNOWLEDGMENT

With this knowledge, I voluntarily consent to the above procedures. I realize that neither the provider nor any personnel at Compassion Care Clinic has made any absolute guarantees to me regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation in these procedures at any time. I waive my right to future litigation regarding my present health condition or result of this procedure by signing this agreement.

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Patient Name (Print)

Patient Signature

Date

**I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.**

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Provider Name (Print)

Provider Signature

Date