Jason R. Litak, M.D.
Fellow of the American College of Mohs Surgery
Santa Monica Dermatology
2001 Santa Monica Blvd. Suite 990W
Santa Monica, CA 90404
(310)829-4484

Patient Name:_____

CONSENT TO TREATMENT- EXCISIONAL SURGERY

1. I agree to the performance of excisional surgery (standard or Mohs technique) and subsequent reconstruction by my physician, Dr. Jason R. Litak, M.D.

2. I am aware that the risks of the procedure include scarring, bleeding, infection, tumor recurrence, and incidental damage to nearby structures such as nerves (usually superficial sensory type causing numbness).

3. I permit photographs to be taken for chart documentation purposes. The photographs and information relating to my case may be used for other professional purposes, such as coordination of care.

4. I hereby freely and voluntarily give my signed authorization and request for this procedure.

_____ _____
Patient (or Guardian) Date

ACMS American College of Mohs Surgery