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Middleburg Hts, OH 44130



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3865 Rocky River Dr. #4
Cleveland, OH 44111

CONSENT FOR IN-OFFICE BIOPSY PROCEDURE

Patient Name: _____ **Procedure Date:** _____

I hereby request and authorize Dr. Yerukhim to perform upon the following procedure:

The above listed procedure is suggested for the treatment of (Diagnosis / es):

Procedure has been explained to me by Dr. Yerukhim and I understand the nature and expected benefits and complications of the procedure. I also understand the discomforts and risks that may arise, as well as possible alternatives to the procedure. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction.

The doctor has explained the risks of this procedure, which include:

I am aware that practice of medicine is not an exact science and that no guarantees have been made to me concerning the results of my procedure.

I confirm that I have read and fully understand the above.

Patient Signature: _____

Date: _____