Stephen N. Horwitz, M.D., .P.A.

AUTHORIZATION FOR MEDICAL TREATMENT
ADMINISTRATION OF ANESTHESIA AND THE PERFORMANCE OF OPERATIONS AND/OR PROCEDURES

1. I do hereby authorize the use of administration of such drugs, anesthetics, and other treatments and the performance of such operation and other procedures as may be deemed advisable, desirable, or necessary for diagnostics, therapeutic, or investigation purposes by Stephen Horwitz, M.D. or by any physician on the medical staff of Skin and Cancer Associates for or upon me or my minor.

2. I further consent to the examination for diagnostic investigational purposes, and disposal by authorities of the above named medical facility of any tissue or parts, which may be removed.

3. I recognize the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT AND THE EXPLANATIONS CONCERNING THE ABOVE ITEMS WERE MADE TO ME.

Signature of Patient

____

When patient is under age of 18 or unable to affix signature

Signature of person authorized to consent for

patient: ________________________________

Witness: ________________________________

Date: ________________ Time: ________________

2999 N.E. 191 Street
PH-1
Aventura, Florida 33180
(305) 933-1151
(305) 933-8055 Fax