BALDONE • REINA
DERMATOLOGY
THE SKIN HEALTH CENTER

Rhonda R. Baldone, M.D.
Board Certified Dermatologist

Rachel S. Reina, M.D.
Board Certified Dermatologist

Request for Medical Treatment

I, ________________________, have presented to Baldone ▪ Reina Dermatology, APMC to obtain medical treatment for myself or my child.

I understand that in order to adequately treat or diagnose my condition, I may need to have a biopsy done or have a lesion frozen with liquid nitrogen, scraped off with a curette or burned off. Some risks associated with these procedures include scarring that may look worse than the original lesion, lightening or darkening of the skin, bleeding, infection, and a change in sensation.

If Dr. Baldone or Dr. Reina feels that one of these procedures is necessary for my or my child's treatment, she will discuss this with me before proceeding with the procedure. I will be given the opportunity to ask any questions about the procedure, as well as to refuse the recommended procedure.

By signing this I acknowledge that I have read and understand the above information.

____________________________________   _______________
Patient/parent signature   Date

_____ I authorize Dr. Baldone or Dr. Reina to give my test results to:
____
____

_____ I do not authorize my results to be given to anyone other than myself.

150 LAKEVIEW CIRCLE, COVINGTON, LA 70433 • 985-892-DERM(3376) FAX: 985-892-2055
www.baldonereinadermatology.com