

AUTHORIZATION/CONSENT FOR PROCEDURE

I hereby authorize Tarun Kothari, MD Krishan Thanik, MD Prasadvarma Penmetsa, MD and whomever he may designate as their assistants, who is referred to as "the Doctor" in the rest of this Consent Form, to perform the following procedures:

- Colonoscopy (Lower GI Endoscopy)
 Gastroscopy (Upper GI Endoscopy)
 Flexible Sigmoidoscopy

For the following conditions:

1. The doctor has explained the condition and the procedure to me. He has explained the purpose of the procedure and alternate ways of treating the condition.
2. In addition to the usual risks of these procedures, I have been made aware of certain risks and consequences that are associated with the procedure(s). These include but are not limited to: Bleeding, infection, and perforation.
3. I understand that during the procedure, the Doctor may discover a condition that he did not know about or perform any additional or different procedures in accordance with the Doctor's judgement that are necessary or advisable while this surgical procedure is being performed.
4. I consent to the administration of moderate (conscious) sedation by a Physician or Registered Nurse as deemed most appropriate for the procedure to be performed. The physician will discuss details regarding risks and alternatives appropriate for the procedure(s).
5. I consent to the administration of medications that may be necessary or advisable before, during or after the procedure(s).
6. I understand the Doctor may have assistants participate with him or under his supervision in this procedure and related care.
7. I understand that a videotape and/or photo(s) may be made of the procedure and consent to this providing my right to privacy is protected.
8. I understand that no guarantees have been made to me about the results of the procedure.

I have read this form. I understand what it means.

Patient Signature

Date

Witness Signature

Doctor's Signature