

Rochester Gastroenterology Associates LLP

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AUTHORIZATION/CONSENT FOR PROCEDURE

I hereby authorize Tarun Kothari, MD Prasad Penmetsa, MD Surinder Devgun, MD and whomever he/she may designate as their assistance, 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:

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1. The Dr. has explained the condition and procedure to me. He/she 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've been made aware of certain risks and consequences that are associated with the procedure(s). These include but are not limited to: bleeding, infection, numbness, stiffness, etc.
 3. I understand that during the procedure, the Doctor may discover a condition that he/she did not know about or was not recognized before the procedure started. Therefore, I authorize the Doctor or his/her assistants to perform any additional or different procedures in accordance with the Doctor's judgment that are necessary or advisable while this procedure is being performed.
 4. At the discretion of the Doctor, I consent to the presence of manufacturer's representatives to aid in the service and correct calibration of the instrumentation. I understand that at no time will these representatives actively participate in my procedure.
 5. I consent to the administration of moderate (conscious) sedation by a Physician or Registered Nurse as the most appropriate for the procedure to be performed. The physician will discuss details regarding risks and alternatives appropriate for the procedure(s).
 6. I consent to the administration of medications that may be necessary revisable before, during or after the procedure(s).
 7. I understand the Doctor may have assistants participate with him/her or under his/her supervision in this procedure and related care.
 8. 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.
 9. I understand that no guarantees of the made to me about the result of the procedure.

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

Patient Signature

Date

Parent/Legal Guardian Signature

Date

Print name

Doctor's Signature

Date

Witness