



**INTERNAL MEDICINE & CARDIOLOGY**  
BRONX MEDICAL-CARDIAC, PLLC.

Gurkan Taviloglu, M.D., FACC, FACP, FCCP

**PERMISSION FOR DIAGNOSTIC PROCEDURE**

1. I hereby authorize Bronx Medical-Cardiac, PLLC. to perform upon me or the named patient, the follow procedures: \_\_\_\_\_  
\_\_\_\_\_ including photographing, videotaping, televising, or other observation of the procedure as may advance medical knowledge or education, with the understanding that my identity will remain anonymous.
2. The nature and purpose of the procedure has been fully explained to me. I have been informed of the expected benefits and complications, attendant discomforts and risks that may arise. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.
3. I understand that during the course of the procedure unforeseen conditions may arise which necessitates procedures different from those contemplated. I therefore consent to performance of additional operations and procedures that the above named physician or associates may consider necessary.
4. I further consent to the administration of such medications as may be considered necessary. I recognize that there are always risks to life and health associated with medication and such risks have been fully explained to me.
5. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedure.
6. I confirm that I am not pregnant nor breast feeding at the present time.
7. I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing. I have crossed out any paragraphs above that do not pertain to me.

Patient/Relative or Guardian: \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_  
(Signature) (Date) (Print Name)

Relationship, if signed by person other than patient \_\_\_\_\_

Witness: \_\_\_\_\_ | \_\_\_\_\_  
(Signature) (Print Name)

- o The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incompetent to sign.

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed procedure, have offered to answer any questions and have fully answered all such questions. I believe the patient/relative/guardian fully understands what I have explained and answered.

Technician/Medical Assistant: \_\_\_\_\_ | \_\_\_\_\_  
(Signature) (Date)

I hereby certify that I have satisfied myself that the patient understands the nature, purpose, benefits, risks of, and alternatives to the proposed procedure. I have offered to answer any questions and have fully answered all such questions. I believe the patient/relative/guardian fully understands what I have explained and answered.

Physician: \_\_\_\_\_ | \_\_\_\_\_  
(Signature) (Date)