

DILATION CONSENT FORM/ HIPAA NOTIFICATION

It is our goal to provide a complete and thorough comprehensive eye examination. To effectively accomplish our goal, we feel it is important to dilate the pupils of your eyes. This will require placing drops in your eyes which will open the pupil and allow a better view of the inside of your eye.

As with many medications, there are some side effects of the drops used to dilate the pupil. These includes sensitivity to light and blurred vision (in most cases the distance vision will be unaffected). The side effects usually last several hours but rarely last as long as 24 hours.

While we believe dilation is an important part of the eye examination process, we understand that you may wish to defer or omit this procedure. **Please indicate your preference below:**

_____ I wish to be dilated today

_____ I do not wish to be dilated at this time; but will return at a later date (there will be no additional charge when you return for routine dilation).

_____ I do not wish to be dilated and agree to hold *Dr. Mary Jo Baize, OD, PA*, harmless as a result of my actions.

Patient/Guardian Signature: _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been offered a copy of *Dr. Mary Jo Baize, OD, PA's* "Notice of Privacy Practices" (version April 14, 2003).

Patients Name _____

Signature _____ Date _____