PERMISSION TO DILATE

The dilation of your eyes is a crucial component of your eye exam. It allows the doctor to check the health of the back of your eye and screen for early signs of disease. The dilation will make you light-sensitive and blur your near vision. Some people also have difficulty with their distance vision, therefore we caution against driving while you are dilated. The duration of the dilation is usually 6-8 hours. If you are having a Pre-LASIK exam, the duration is approximately 24 to 48 hours.

I give permission for my eyes to be dilated.

Signature: ______________________________ Date:______________

Initials	Date	Initials	Date
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

I, ____________________________, have received a copy of this office's Notice of Privacy Practices.
(printed name)

Signature:____ Date: ____________________

You have my permission to discuss my medical care or billing information with:

Name	Relationship	Phone
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

I wish to be contacted in the following manner (check all that apply):

- ☐ Home telephone – o.k. to leave detailed message
- ☐ Home telephone – leave callback number only

- ☐ Work telephone – o.k. to leave detailed message
- ☐ Work telephone – leave callback number only

- ☐ O.k. to mail to my home address
- ☐ O.k. to mail to my work address

For office use: Acknowledgement could not be obtained because ______________________________.