CONSENT & RELEASE

Version 09.24.2015

CONSENT TO TREAT

I hereby, authorize and direct the doctor(s) at the **Williamson Allemond Regional Eye Center** to assess, diagnose, and treat my medical condition(s). I further authorize and direct the doctor(s) and their designated staff to prescribe medications for me and perform any procedures on me which in their judgment is advisable for my well-being, and to provide such additional services as he or she may deem appropriate. I understand these medications and/or procedures may come with associated benefits as well as risks and/or side effects and these will be discussed with me at the time of treatment.

I acknowledge I have read and understand this consent form (or that it has been read to me). I acknowledge that I understand the information contained in this consent form, including all of the medical terminology, about which I have asked if unsure. I have been given an adequate opportunity to ask whatever questions I have about the treatment and my care, and all of my questions about the treatment have been answered by my physician and/or his associates or assistants in a satisfactory manner. I understand the nature and purpose of the treatment, its risks, and the alternatives.

This consent form is valid until it is expressly revoked and the revocation is communicated to my physician. I understand and agree that it is my responsibility to communicate any revocation of this consent to my physician and/or the medical staff.

PATIENT SIGNATURE (OR REPRESENTATIVE): ___________________________________DATE:__________

NOTICE OF PRIVACY PRACTICES & RELEASE OF INFORMATION

I have received a copy of the Notice of Privacy Practices of the Williamson Allemond Regional Eye Center. This Notice describes how my health information may be used or disclosed. I understand that I should read it carefully and ask questions if there is any part of the Notice that I do not understand. I am aware that the Notice may be changed at any time.

*If you are a minor, your healthcare provider has the right to disclose protected health information to your parents or guardians should he/she deem necessary.

By signing below, I attest that all of my questions have been answered satisfactorily, and I understand that I may obtain a copy of the Notice if I wish.

PATIENT SIGNATURE (OR REPRESENTATIVE): __________________________________ DATE:____________

In addition to those entities listed in the Notice, I am authorizing the Williamson Allemond Regional Eye Center to release my personal health information to the following individuals listed in the table below. I understand I may change or revoke this authorization at any time by submitting a written letter declaring my desires to add or remove individuals and by presenting my ID.

Date	Name	Relationship To Patient	Phone Number