**NOTICE OF PRIVACY PRACTICES**

Our Notice of Privacy Practices provides information about how Florida Eye Associates and its representatives may use and disclose protected health information about you.

You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by requesting it from the personnel at check-in. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, or health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I acknowledge and agree that I have access and can receive a copy of the FEA Privacy Policies.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

**CONSENT TO COMMUNICATIONS**

Consent to communications will enable Florida Eye Associates to provide you with timely, pertinent information regarding your healthcare. By signing below, you consent to communication via mail, e-mail, telephone, voicemail ,and or text SMS message by Florida Eye Associates, for messages regarding your healthcare. Message frequency varies and text message and data rates may apply. You may “Opt-Out” of text messaging by replying “STOP” at any time. You consent to the exchange of Healthcare and Pharmacy information with your approved network of providers, via a secure electronic health information exchange platform.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

**INFORMATION REGARDING DILATING EYE DROPS**

Your exam may require dilation. Dilating drops are used to dilate the pupils to properly assess and diagnose certain conditions. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself. Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. I authorize my physician or his/her designated assistants to administer dilating eye drops

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

**We maintain consent of our patients in our practice management system.**