Alaska EyeCare CENTERS

Patient Consent For Treatment

ADULT OR MINOR

Treatment: The undersigned consents to the procedure(s) that may be performed by any providers at Alaska Eye Care Centers, APC. These may include, but not limited to, eye health examinations, follow-up visits, dilation, Punctal plugs, treatment for eye disease, fitting for spectacles, fitting of contacts under the general and special instruction of the patient's Optometric physician.

If a minor, I, hereby acknowledge and give permission to Alaska Eye Care Centers, APC to provide eye health care for said minor.

I, give permission for my son/daughter to be dilated: ☐ Yes ☐ No

In my absence, I give authorization to the person(s) listed below, to obtain medical treatment for the below said minor(s). This grant of temporary authority shall begin on (date)_____, and shall remain effective until terminated by the undersigned Parent or Legal Guardian.

Name of Individual (Printed): _____ Relationship: _____

Minor lives with ☐ Both Parents ☐ Mother ☐ Father ☐ Guardian

Mother's Address: _____

DOB: _____ Home phone: ☐ _____ Work Phone: ☐ _____

Father's Address:_____

DOB: _____ Home phone: ☐ _____ Work Phone: ☐ _____

Guardian's Address: _____

DOB: _____ Home phone: ☐ _____ Work Phone: ☐ _____

I, understand that I am financially responsible for any balance due arising from medical treatment.

Use and Disclosure of Health Information:

I have been provided with a copy of the Notice of Privacy Practices. I, understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Alaska Eye Care Centers, APC is not required to agree to the restrictions requested.

I, understand that I may revoke this consent in writing, except to the extent that Alaska Eye Care Centers, APC has already taken action in reliance thereon.

I wish the following restrictions to the use or disclosure of my health information:

Please check a box: ☐ Restrictions: _____ ☐ None

I, hereby authorize the release of any information including diagnosis and records of any treatment or examination rendered to me, to myself or other appropriate caregivers as I may request.

Patient's Name (if not a minor, please print): _____

Patient's Signature :_____ Date: _____

Minor's:

Minor Patient's Name: _____ DOB: _____

Minor Patient's Name: _____ DOB: _____

Minor Patient's Name: _____ DOB: _____

Minor Patient's Name: _____ DOB: _____

Minor Patient's Name: _____ DOB: _____

Printed Name of Parent or Legal Guardian: _____

Signature of Parent or Legal Guardian: _____ Date: _____

Alaska EyeCare CENTERS

Anchorage
1345 West 9th Avenue | Anchorage, Alaska 99501
907-272-2557 p | 907-274-4932 f

Wasilla
1700 East Parks Hwy. | Wasilla, Alaska 99654
(907) 376-5266 p | 907-373-1887 f