Patient Account #: _____

vpos
Virginia Pediatric
Ophthalmology Specialists

HIPAA CONSENT FORM

HIPAA is the Health Insurance Portability and Accountability Ace of 1996.
Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose Private Health Information (PHI) about you. You have the right to review our NPP before signing this consent. As provided in our NPP, the terms to our NPP may change, in accordance with change in Federal regulations. The current Federal guidelines may be obtained by viewing the link on our website, on this page. You have the right to request that we restrict how PHI about you is used or disclosed. We are not required to agree to this restriction, but it we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. If you have any questions, you may contact our Privacy Officer: Lorraine Crowe at 804-272-8040

Authorized Representative: _____

Relationship to Patient: _____

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

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's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Wortham/ Dr. Doerr and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____
Patient (or person authorized to sign for patient)   Date