Patient Name: _____

Patient No.#: _____

AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION FOR TREATMENT, PAYMENT & HEALTH CARE OPERATIONS and NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have the legal authority to authorize the examination and treatment of the above listed patient by AEG Vision managed practices. I understand that the examination and treatment may include the use of various exams or tests (including, but not limited to: comprehensive eye examinations, glaucoma testing, pupil dilation, and contact lens fitting), medications (including dilating or numbing agents and dry eye assessment drops), and other diagnostic procedures and tests normally provided in an optometry practice.

I understand that my medical information provided by me, and collected during evaluation, including recordings (photographs, video, electronic), may be collected, used, and disclosed only as necessary for:

- Treatment, payment, and healthcare operations purposes,
- Public health purposes, health oversight activities, accreditation, and other activities that promote wellness; and
- Other purposes as permitted by law.

If retinal imaging, foreign body removal, punctual occlusion, an amniotic membrane graft, dry eye disease treatment or other procedures are required and not emergent in nature, then this will be explained to me by an Optometrist or Optician. If this occurs, I will be asked to give additional written consent for these procedures.

By agreeing to receive treatment:

- I authorize the examination and treatment of the patient as the legal representative (or self, if the patient).
- I acknowledge:
  - If this is my first visit to the practice that I have received a copy of the AEG Vision Notice of Privacy Practices.
  - I have the right to review the AEG Vision Notice of Privacy Practices before signing this form.
  - As provided in the Notice, the terms of the Notice may change. If we change our Notice, I am aware the Notice of Privacy Practices can be obtained from our website www.aegvision.com, or from the practice location, at any time.
- The Notice of Privacy Practices provides information about how we use and disclose health information about you. I consent to the collection and sharing of information as indicated above and the uses and disclosures detailed in the Notice of Privacy Practices, including releasing my medical information to my insurance company(s) as needed to process my insurance claim(s).
- I understand I have the right to request that AEG Vision and its affiliated practices restrict how protected health information about me is used or disclosed for treatment, payment or health care operations, however, we are not required to agree to this restriction.
- I understand this authorization applies and extends to subsequent visits and appointments at this practice as well as other AEG affiliated practice locations, and that I have the right to revoke this consent, in writing, except where we have made disclosures based upon your previous consent.

I certify that I have read and understand the above statements, I have been provided a copy of the AEG Vision Notice of Privacy Practices if this is my first visit, and that I am providing my consent to treat.

_____	_____	_____	_____AM/PM
Patient/Legal Representative Signature	**Relationship to Patient**	**Date**	**Time**
_____	_____		
Legal Representative Name (Print)	**Name of Patient (Print)**		