



Informed Consent For Pupillary Dilation

I understand the doctors of Lifetime Vision Care recommend dilation of my pupils to more thoroughly evaluate the internal health of my eyes. Florida Law requires dilation for a patient's first comprehensive eye examination unless there are medical reasons or personal reasons why it cannot be performed. Without dilation, serious eye diseases, such as diabetes, retinal detachment, or malignant tumors (which can result in blindness, loss of an eye, or death) could be present and not detected by the doctor. I understand there is not an alternative procedure that can replace dilation of my pupils. I agree to indemnify, hold harmless and waive and release from any and all claims, legal actions and attorney fees, which may arise as a result of my failure to comply with the recommendations of Lifetime Vision Care and their employees, officers, directors and agents. I am aware that pupillary dilation carries a very small risk of complication including angle closure glaucoma, and will accept medically necessary treatment if complications arise.

Please check one:

- Yes, I want to be dilated.
- I will be responsible for rescheduling my dilation.
(If more than one week later, an office visit charge will apply)
- I refuse dilation at this time. (you may change this at any time)

Printed Name: _____ Date: _____

Signature: _____ (Parent or guardian if a minor.)

Informational Safety Statement

Lifetime Vision Care is required to inform all patients that **Polycarbonate** plastic is the safest, most impact resistant material for eyeglass lenses. Your lifestyle, including your activities, should be considered when ordering eyewear for yourself or your family.

I have read the above safety statement: _____

Signature