



Informed Consent For Pupillary Dilation

I understand the doctors of Lifetime Vision Care will be recommending dilation of my pupils to more thoroughly evaluate the internal health of my eyes. I am aware that Florida Law requires pupillary dilation for a patient's first comprehensive eye examination unless there are medical reasons or personal reasons why it cannot be performed. I recognize that 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 be 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 dilation recommendation 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. I am aware that dilation may temporarily blur my vision and will discuss the expected effects with the doctor.

Please check one box below, then sign and date:

- I have read and understand the above and agree to be dilated.

- I will return for dilation at a later date. I will be responsible for rescheduling my dilation. (If scheduling more than one week later, an office visit charge will apply)

- I have read and understand the above and do not want dilation today (this can be changed in the future).

Printed Name: _____ Date: _____

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