

Consent for Care – Fishman and Sheridan Eyecare Specialists

Information Regarding Dilating Eye Drops

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the eye specialist 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 eye specialist 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. We can provide you with disposable sunglasses to help with light sensitivity after your examination, should you need them.

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 Craig Fishman M.D., Jeffrey Sheridan M.D., Gustavo Munguba, M.D., Glenn Pieschke, O.D., and/or other qualified healthcare professionals working under their direction to administer these drops. The eye drops are necessary to diagnose my condition.

I have been given the opportunity to ask questions about the use of dilating eye drops, and all my questions have been answered to my satisfaction.

By signing below, I, the undersigned patient (or legal guardian of the patient), hereby voluntarily consent to medical care and treatment by Fishman and Sheridan, M.D., P.A., and its physicians, nurses, and other healthcare professionals.

I understand that this care may include, but is not limited to:

- Medical examinations and evaluations.
- Diagnostic tests, such as laboratory work, X-rays, and other imaging studies.
- Medical and surgical treatments deemed necessary by my healthcare provider.
- The administration of medications.
- Other procedures related to my medical diagnosis and care.

I acknowledge that the nature and purpose of these examinations, tests, and treatments will be explained to me by my healthcare provider, and I will have the opportunity to ask questions about my care. I understand that no guarantees have been made to me concerning the results of any examination, test, or treatment.

I also consent to the release of my protected health information to insurance providers, other healthcare professionals involved in my care, and as otherwise permitted or required by law, in accordance with the Notice of Privacy Practices of Fishman and Sheridan, M.D., P.A., which I have received or have been offered.

I understand that I have the right to refuse any treatment or procedure at any time, and that my refusal will be documented in my medical record.

This consent will remain in effect for the duration of my care at Fishman and Sheridan, M.D., P.A., unless I revoke it in writing.

Patient or Legal Guardian Signature

Date

