MASSACHUSETTS COLLEGE of PHARMACY and HEALTH SCIENCES

CONSENT AND AUTHORIZATION

Patient Name: _____ Date: _____

By signing this Consent and Authorization in the space below, you agree, for yourself as the patient, or on behalf of the patient identified above, as follows:

- I understand that I am establishing eye care at The Eye and Vision Center and that I will be examined and receive care based on my diagnosis and goals. I authorize and direct The Eye and Vision Center to provide such examination and care.
- I am aware that The Eye and Vision Center is part of the MCPHS University School of Optometry, an institution of higher education at which students receive optometry education and training. I consent to have the faculty and students of the MCPHS University School of Optometry perform such examinations and tests as are necessary, including but not limited to ocular pictures, pressure check, and visual fields.
- I understand and agree that protected health information obtained as a result of this examination and treatment may be used or disclosed for the purpose of advancing the educational objectives of MCPHS University, including the training of School of Optometry students.
- I understand and agree that my de-identified data, including but not limited to clinical exam data, diagnostics, or treatments, may be used and disclosed by the MCPHS University School of Optometry for research purposes.
- I give my consent and permission to the employees and students of the MCPHS University School of Optometry to take and publish photographs of me or the patient identified above for education, research, and other purposes that further the educational goals of the MCPHS University School of Optometry. [check one]:

  □ Yes □ No
- If English is not my first language, I confirm that an interpreter and/or translation services were offered to me and were provided, if requested [check one]:

  □ Yes □ No □ N/A
- I authorize my insurance benefits, including Medicare and/or Medicaid, to be paid directly to The Eye and Vision Center. I understand that I am financially responsible for any balance. I also authorize The Eye and Vision Center to release any information required to process my insurance claims. [check one]:

  □ Yes □ No □ N/A
- I understand the statements and agreements set forth in this Consent and Authorization. I understand that I have the right to have any questions regarding my treatment answered by my clinician, and I agree that all of my questions have been answered. I acknowledge and agree that The Eye and Vision Center has the right to refuse care.

_____ Date: _____

Signature of Patient or Patient's Legal Guardian

Print name of legal guardian (if applicable) _____

_____ Date: _____

Signature of interpreter (if applicable)