

EYE CONCERN, INC

Consent for Treatment and Authorization to Release Information

I, _____, hereby authorize **Eye Concern** through its appropriate personnel, to perform or have performed upon me the appropriate assessment and treatment procedures.

I further authorize **Eye Concern** to release to appropriate agencies, such as the State Insurance Commissioner, any information acquired in the course of my examination and treatment. I understand that **Eye Concern** follows HIPPA regulations with regard to the protection of my medical information.

Patient/Guarantor: _____ **Date:** _____

I hereby grant Eye Concern, Inc. permission to photograph my face and eyes. It is understood that these photographs may be used by Eye Concern, Inc. for medical, educational, and scientific purposes; as well as displayed for portfolio purposes, i.e. on the Internet.

Signature _____ Date _____