Jones Oakland Vision Group, P.A.
James V. Jones, O.D.
888 Memorial Drive
Oakland, MD 21550

JONES OAKLAND VISION GROUP, P.A. (JOVG) and JAMES V. JONES, O.D. (JVJ)

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to JOVG, (the "Practice") and JVJ (the "Physician") using and disclosing my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I hereby acknowledge that: I have had the right to review the Practice's Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that the Practice and/or the Physician reserves the right to revise its Privacy Policy at any time. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request to the Practice and or the Physician.

Consent to Calls/Mail/Email

I hereby consent to the Practice and/or the Physician calling my home, cell phone or other designated location and leaving a message on my voicemail or in-person in reference to any items that assist the Practice and/or Physician in carrying out TPO, such as appointment reminders, insurance items, eye glass & prescription contact lens, and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment.

I hereby consent to the Practice and/or the Physician mailing to my home or other designated location any items that assist the Practice and/or the Physician in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I hereby consent to the Practice and/or the Physician e-mailing me any items or communications that assist the Practice and/or the Physician in carrying out TPO. I understand that the Practice and/or the Physician may share my PHI with my family unless I sign the objection to do so. Sign the line right below, only if you object to PHI and TPO being shared with your family.

I understand that I have the right to request that the Practice and/or the Physician restrict how it uses or discloses my PHI to carry out TPO. However, the Practice and/or the Physician is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Practice and/or the Physician use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information, I am also consenting to have my PHI and TPO shared with my Family, unless I have signed the line above objecting to the sharing of my PHI and TPO with my family.

I understand that I may revoke my consent in writing, except to the extent that the Practice and/or Physician has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that the Practice and/or Physician may decline to provide treatment to me.

_____ _____

Signature of the Patient or Legal Guardian | Date

_____ _____

Patient's Name | Phone Number—(Cell / Home)

Patient's E-mail Address _____

Jones Oakland Vision Group ~ James V. Jones, OD

Patient Informed Consent for Pupil Dilation

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the optometrist 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 optometrist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself.

Dilation is necessary to evaluate the internal health of your eyes, and to look for signs of eye disease, diabetes, retinal detachment and/or malignant tumors.

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 agree to indemnify, hold harmless and waive and release from any and all claims, legal actions and attorney fees which may arise from any normal, unforeseen and/or adverse reactions from dilation drops.

Please check one:

___ I understand the risks and choose to have my eyes dilated.

___ I refuse to be dilated.

_____ _____

Patient (or person authorized to sign for patient) Date

_____ _____

Witness Date