



300 S HIGHWAY 35, SUITE 300. EATONTOWN, NJ 07724 | 732.222.7373

1963 NJ-34 BUILDING B, SUITE 101. WALL TOWNSHIP, NJ 07719 | 732.223.6555

100 COMMONS WAY # 230, HOLMDEL, NJ 07733 | 732.796.7140

180 WHITE ROAD, SUITE 202. LITTLE SILVER, NJ 07739 | 732.219.9220

INFORMATION REGARDING DILATING EYE DROPS

**Listed below is helpful information on the testing being performed during your visit.
If you have any questions, please let us know.**

Dilating eye drops enlarge the pupil of the eye to allow for the examination of the inside of your eye. These drops usually cause blurred vision. The length of time your vision will be blurred and the degree of eyesight impairment varies from person to person.

Driving even in low light conditions may be difficult or impossible after an examination with dilating drops, and, if possible you should not drive yourself afterwards. Instead, we strongly suggest you make alternate arrangements for transportation after your examination. If you choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself or others. Also, we strongly suggest you use sunglasses to reduce your increased sensitivity to light while driving.

By signing below you authorize your Atlantic Eye provider and or their nurses or other assistants to administer dilating drops during the course of your treatment. You understand and acknowledge that you have been warned of the potential risks that dilating eye drops may have on your ability to drive and will take appropriate steps to reduce this risk.

NOTICE OF PRIVACY POLICIES

The following policy describes how your medical information may be used and disclosed by the Atlantic Eye Physicians, PA and/or the Atlantic Surgery Center. Please review it carefully. The privacy of your health information is important to us. This notice is being supplied as a part of our requirements of the health insurance portability and accountability act (HIPAA) that became effective on April 14, 2003 and updated September 23, 2013 (Final Omnibus Rule).

Please list the full names of the people you authorize to have access of your medical information:

Do you authorize Atlantic Eye to leave messages containing your medical information for you on your home and / or cell phone? YES NO

By signing below, I acknowledge that I have read and understand all of the above information.

Patient Name: _____ Date _____

Representative _____ Relation to Patient _____