OPTOMAP CONSENT FORM

The Optomap eliminates the need to be dilated, in most cases.

______I elect to have the Optomap Digital retinal Image of my retina for $39 or less depending upon insurance

______**I DECLINE** the Optomap Retinal Imaging and am choosing to be dilated. I understand dilation will cause blurry vision for approximately 6 hours and light sensitivity. **Driving is not recommended**.

______**I DECLINE** both Optomap and dilation. (I would like to discuss it further with my doctor) I understand that the potential for partial loss or total loss of vision may exist due to undetected eye disease. I therefore release Dr. Cooper from all liability resulting from failure to diagnose or treat any eye condition due to lack of diagnostic information, which could have been performed by obtaining this test.

Print name: _________________________ Signature: ______________________ Date: _________