LIOC LONG ISLAND OPHTHALMIC CONCEPTS
TRANSFORMING EYECARE

Primary Location of Care:

Bellmore ☐ **Great Neck** ☐ **Huntington** ☐ **Little Neck** ☐

Patient Consent For Treatment

I voluntarily give my permission to the health care providers of LIOC and such assistants as deemed necessary to provide medical services to me. I understand that by signing this form, I am authorizing them to treat me for as long as I seek care from LIOC's providers, or until I withdraw my consent in writing. I hereby authorize LIOC's providers to obtain my medication history from the community pharmacies and/or Pharmacy Benefit Managers for the purpose of continued treatment.

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Signature of Patient or Guardian Date

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Printed Name of Patient or Guardian Relationship to Patient