Family Optometric Associates P.C.
Navy Exchange
1560 Mall Drive Norfolk, VA 23511

COVID-19 Pandemic Essential Eye Exam and Treatment Consent Form

_____Neither I, nor anyone living in my immediate household, currently, or in the last two weeks, has had a **fever, cough, sore throat, loss of smell/taste or other flu-like/cold symptoms**.

_____To the best of my knowledge, I do not have, nor have I been in direct contact with someone who has confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last 14 days.

Have you received the COVID-19 Vaccination? Yes No

I have answered the health questions above honestly and to the best of my knowledge. I understand that Family Optometric Associates, P.C., its doctors, and staff are taking precautions to limit any potential exposure I may have to the COVID-19 virus. I also understand that there is no definitive way to eliminate potential exposure by one hundred percent. By signing this form below, I agree that I will not hold Family Optometric Associates, P.C., its doctors, or staff responsible should I, or someone I come in contact with, become positive or presumptive positive diagnosed with the COVID-19 virus. There are certain inherent risks associated with an eye exam during a pandemic and I assume full responsibility for personal illness that may result and further release and discharge Family Optometric Associates, P.C. and its doctors and staff for injury, loss or damage arising out of my visit. I understand that COVID-19 infection can lead to illness, disability, or even death and knowingly take the risk of exposure as I deem my eye exam to be essential to the maintenance of my vision.

_____
Patient(s) Name Printed:

_____
Patient/Guardian Signature:

Date: _____

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Family Optometric Asscociates to release my records and any information requested to the following individuals.

1. **_____ Relation to Patient:_____**
2. **_____ Relation to Patient:_____**
3. **_____ Relation to Patient:_____**
4. **_____ Relation to Patient:_____**

_____ _____

Patient Name (PLEASE PRINT) Date

_____

Patient Signature