Arbor Eyecare

Dilation Waiver

I understand that my eye doctor has recommended dilation of my eyes, and I have declined dilation. I have been advised that failure to complete these tests may result in not detecting or the misdiagnosis of certain eye conditions that may lead to loss of vision or blindness. I understand these risks and have been advised in full of the consequences of my decision.

I have knowledge of the risks involved, and I assume such risks and all expenses in the event of accident, illness, or incapacity. I also agree that the terms here of shall serve as an assumption of risk and release for my heirs, estate, executor, administrator, and all members of my family.

I have read this form, understand its contents, and agree to its terms.

Name of Patient: ____

______________________________ ______________
Signature of Patient/Guardian Date

Name of Doctor: ____

______________________________ ______________
Signature of Doctor Date

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