**My Signature Indicates:**

1. I give the following persons permission to have information about my medical record.
   **If applicable (under 18) – In my absence I give permission to BRING my child to their visit.**

2. I authorize the staff of Boston University Eye Associates to administer eye drops which are required for the eye exam.

3. Acknowledgement of Receipt of Notice:
   I’ve been offered the opportunity to read Boston University Eye’s Associates “Notice of Privacy Practices”

**Signature of Patient, Parent or Guardian:** ___________________________ **Date:** ________