Co-Management Consent

ClearView EYE CLINIC

Commitment.
Community.
ClearView.

It is my desire to have my optometrist perform my follow-up care following surgery. I further authorize you and my optometrist to share any information as it relates to my health and/or vision.

Patient Name _____ Phone _____

Patient Signature _____ Date _____

Optometrist Confirmation

I am referring the above-named patient for cataract and/or PCO evaluation. Below you will find notes regarding my findings and/or recommendations:

Referring Physician Signature _____ Date _____

FAX: 208.883.6557

ClearView Eye Clinic
CVeyes.com

LEWISTON
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