Retina of Auburn & Metro-Columbus

Ram Peddada, MD, DSc
Board Certified . Fellowship Trained

(334) 521-0041 (Auburn and Dothan)
(706) 221-9702 (Columbus)

PATIENT CONSENT FOR LASER TREATMENT

The nature of my eye condition has been explained to me and the proposed treatment has been described. The risks, benefits alternatives and limitations of the treatment have been discussed with me. The risks specifically include no improvement in my vision, persistent or new bleeding in the eye, loss of vision, swelling or other changes to my eye. All my questions have been answered.

I am willing to accept the potential risks that my physician has discussed with me.

I hereby authorize Ram Peddada, MD, to perform laser treatment

for _____

in my right eye / left eye

at regular intervals as needed based on his clinical judgment. This consent will be valid until I revoke it by refusing the laser treatment or my condition changes to the point that the risks and benefits of this medication for me are significantly different.

_____ _____
Patient's Signature Date

_____ _____
Patient Name ID#

785 N. Dean Road, Suite 100,
Auburn, AL 36830

303 Regency Court,
Dothan, AL 36305

1240 Brookstone Centre Pkwy,
Columbus, GA 31904