

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Permission to send assessment & other communications via: Text? ☐ Yes ☐ No Email? ☐ Yes ☐ No

How did you find me? \_\_\_\_\_

Birthdate / Age: \_\_\_\_\_ Gender Identity: \_\_\_\_\_

What is the primary reason for your visit today? \_\_\_\_\_

What areas in your health/life are you working to improve? \_\_\_\_\_

### Informed Consent & Release for Iris Photography Assessment

I hereby attest and agree to the following:

- ☐ I understand that all evaluations/analysis performed by Robin Carey are **designed to evaluate my inherent constitution and temperament for the sole purpose of helping me to improve my general health through nutrition, habits and attitudes**. I further understand that said evaluations cannot determine specific disease conditions I may have and **do not replace the diagnostic services offered by licensed medical physicians**.
- ☐ I understand that Robin Carey **neither claims nor implies that any instruction, advice, counsel, suggestions, recommendations, services or products** she or her representatives provide, whether in person or by mail or by telephone, **will cure, treat, prevent or mitigate any disease condition**; but are **provided solely for the purpose of education** based on the science of Holistic Iridology® curriculum as taught by the International Institute of Iridology®. **I understand it is my responsibility to verify the suggestions provided are safe for me** by researching contraindications, allergic reactions and general physical safety.
- ☐ I certify that Robin Carey or her representatives have not suggested that I cease any medical care I may be undertaking. **I understand that the decisions I make regarding my health care and the health care of those under my guardianship are my responsibility** and certify that I will not hold Robin Carey or her representative responsible for the consequences of my decisions.
- ☐ I authorize the use of **photographs of my eyes** to Robin Carey and her representatives **to be used for educational or promotional purposes** without disclosing my personal information or identity. I waive my right to any royalty or other compensation regarding the use of said photographs.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**If client is under 18 years of age:**

I, \_\_\_\_\_ give permission for my child  
\_\_\_\_\_ to receive an Iris Photography Assessment.

Guardian/Parent Signature: \_\_\_\_\_ Date \_\_\_\_\_