Robert M. Allar, MD
Diseases of the Retina & Vitreous

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630-717-1311 and 847-844-8455

DISCLOSURE OF INFORMATION

In the event that Robert Allar, MD or his staff is unable to contact me, I give full permission to Robert Allar, MD or his staff to contact the individuals that I have designated below for the purpose of disclosing information pertinent to my case. This would include but not be limited to information regarding pathology reports, laboratory test, fluorescein or ultrasound testing results, scheduling, and business or insurance information.

By my signature below, I agree to hold harmless and waive any liability against Robert Allar, MD or his staff for the disclosure of information to the individual (s) designated below.

1. Name: _____
   Relationship: _____
   Contact Phone Number: _____

2. Name: _____
   Relationship: _____
   Contact Phone Number: _____

_____ _____
SIGNATURE **DATE**

I do not agree to allow Robert Allar, MD and his staff to disclose any medical information regarding myself to any individuals other than myself. (This does include scheduling information)

_____ _____
SIGNATURE **DATE**

____ I give my permission to access my pharmacy portal or other providers for accurate medication records.