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**Robert M. Allar M.D.**  
*Retina and Vitreous Specialist*

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**Patient E-mail Address**

Please fill out your e-mail address for future portal access to your electronic health record in our EHR system.

**Date:**

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**Patient Name:**

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**Patient E-mail Address:**

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**I Do Not want to provide my e-mail address.**

**I Do Not have an e-mail address.**