



Janigian Retina Associates

Diseases and Surgery of the Retina and Vitreous
Ocular Inflammatory Diseases

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Confidentiality Release

I hereby authorize Janigian Retina Associates to speak with the following (relatives, friends, etc) individuals regarding my medical condition.

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

I understand I may revoke this authorization at any time by informing Janigian Retina Associates in writing.

Patient Name – Please print

Signature of Patient or Representative

Date

Relationship to the patient (if other than patient)

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