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Waiver/Privacy Agreement

Patient Name: _____

D.O.B: _____

Contact#: _____

Please check one

I do not give VPG permission to share any of my : _____ Medical Labs
_____ All Information

Contact Name: _____

Contact Phone Number: _____

I give VPG permission to share my : _____ Medical Labs
_____ All Information

Contact Name: _____

Contact Phone Number: _____

Signature of Patient

Date

Witness

Date