

FAX PREVIEW



REFILL AUTHORIZATION REQUEST

Sent on 11/26/2018

124 S. GLENDALE AVE
GLENDALE, CA 91205
TEL: (877) 570-7787
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PATIENT NAME

Raymond Shirvanyan

DATE OF BIRTH

01/08/2001

PHONE

8181111111

ADDRESS

111 Central Ave,
Glendale, CA. 91111

PHYSICIAN NAME

*Ollivander Hemingway

PHONE

8234234

FAX

899779

ADDRESS

234 Celtic Circle,
San Francisco, CA. 34534

RX NUMBER	MEDICATION	QTY	LAST FILL	DIRECTIONS	
3453453452	GABAPENTIN 300MG CAP	3		1 150mg tablet each night	<input type="checkbox"/> AUTHORIZED WITH __ ADDITIONAL REFILLS
3453453452	GABAPENTIN 300MG CAP	3		1 150mg tablet each night	<input type="checkbox"/> AUTHORIZED WITH __ ADDITIONAL REFILLS

PLEASE CHECK ONE:

DOCTORS REMARKS:

<input type="checkbox"/> ALL ABOVE SCRIPTS ARE AUTHORIZED FOR __ ADDITIONAL REFILLS	_____
<input type="checkbox"/> SCRIPTS ARE INDIVIDUALLY AUTHORIZED IN THE ABOVE LIST	_____
<input type="checkbox"/> NOT AUTHORIZED. PATIENT NEEDS TO CALL DOCTORS OFFICE	_____

AUTHORIZED BY

SIGNATURE

DATE

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