



REFILL AUTHORIZATION REQUEST

Sent on 01/10/2019

124 S. GLENDALE AVE
GLENDALE, CA 91205
TEL: (877) 570-7787
FAX: (877) 475-2383

PATIENT NAME	DATE OF BIRTH	PHONE	ADDRESS
*Rhonda Mercer	06/12/1966	9393838482	2938 Chariot Rd., Fountain Valley, CA. 93049
PHYSICIAN NAME	PHONE	FAX	ADDRESS
*Roger Klein	3242343243	8884732963	435 Alicia Pkwy., Aliso Viejo, AR. 93845

RX NUMBER	MEDICATION	QTY	LAST FILL	DIRECTIONS
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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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