



From: PETER/ Walgreens

Fax: (305)-390-3669 / (760)-284-9313

Attention To: DR. GARY I LEVINE MD

Date: 30/08/24

Number of Pages Including Cover: 2

Subject: PRIOR AUTHORIZATION FORM/URGENT

PLEASE INCLUDE RECENT MEDICAL NOTES AND FACE SHEET

Confidentiality Notice: Confidential Health Information Enclosed

Protected Health Information (PHI) is personal and sensitive information related to a person's health care. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

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**HIPAA COMPLIANT PHYSICIAN AUTHORIZATION FORM TO
CONFIRM AN ACTIVE PATIENT**

TO: DR. GARY I LEVINE MD

Address: 101 Heart Dr

Phone: 2527444611 **Fax:** 2709883298

RE: **Patient Name:** Janice Williams

DOB: 11/15/1943 **MBI:** 8GF1QR3FD35 **PT Phone:** 8562204840

Address: 2817 Holly Glen Dr, APT D, Greenville, NC, 27834

- ✓ **This is just an active patient authorization form so clinical or office visit notes of the above mentioned are required.**
- Please authorize whether the patient is still under the care at this office.
 - Please fax this form back within 48 hours so that we can follow up with you on patients refill accordingly.
 - If the patient has changed or switched to another Provider, please mention providers name below.

I undersigned; certify that the above patient is under my care and being treated at our facility. I certify that this information is true and correct and as per as HIPAA Compliance. The above-mentioned information will strictly remain confidential.

Treating Physician OR FNP Signature

Date: 30/08/24

NPI: 1548253693

Phone: 305-419-0207

Return Fax: 305-390-3669