



From: PETER/ Walgreens

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

Attention To: RYAN MORRISON MD

Date: 30/08/24

Number of Pages Including Cover: 2

Subject: PRIOR AUTHORIZATION FORM/URGENT

**PLEASE INCLUDE RECENT MEDICAL NOTES AND FACE
SHEET**

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

TO: RYAN MORRISON MD

Address: 4602 MacCorkle Ave SE

Phone: 3042057535 **Fax:** 502-340-5900

RE: **Patient Name:** Nancy Flemings

DOB: 6/5/1955 **MBI:** 1CT1VX7NC94 **PT Phone:** 3048966291

Address: 139 Heartstrings Ave., Mount Gay, WV, 25637

- ✓ **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: 1760702120

Phone: 305-419-0207

Return Fax: 305-390-3669