**From: PETER/** Walgreens
**Fax:** (305)-390-3669 / (760)-284-9313

**Attention To: DESTINY ETHERIDGE MD**

**Date:** 30/08/24

**Number of Pages Including Cover:** 2

**Subject: PRIOR AURTHORIZATION FORM/URGENT**

## PLEASE INCLUDE RECENT MEDICAL NOTES AND FACE SHEET

# HIPAA COMPLIANT PHYSICIAN AUTHORIZATION FORM TO CONFIRM AN ACTIVE PATIENT

**TO:** DESTINY ETHERIDGE MD

**Address:** 1720 W Broadway Suite 107,

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

**RE:** **Patient Name:** elsie jones

**DOB:** 4/11/1948 **MBI:** 2w42u29nj29 **PT Phone:** 5024488035

**Address:** 8514 River Terrace Dr, Louisville,, KY, 40258

- ✓ **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:** 1871099002

**Phone: 305-419-0207**

**Return Fax: 305-390-3669**