HIPAA COMPLIANT PHYSICIAN AUTHORIZATION FORM TO CONFIRM AN ACTIVE PATIENT

TO: Tammy L. Plondke, APNP

Address: 610 E TAYLOR ST `

Phone: 608-326-6466 **Fax:** 608-326-6466

RE: Patient Name: Beverly Masino

DOB: 1/4/1935 **MBI:** 7te2j57mq24 **PT Phone:** 6083262696

Address: 505 S Buchanan St

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.

Return Fax: 305-390-3669