



**From:** PETER/ Walgreens

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

**Attention To:** CLIFTON WALES SALMON JR. M.D.

**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**

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

**TO:** CLIFTON WALES SALMON JR. M.D.

**Address:** 104 MORRIS CIR

**Phone:** 318-927-6777      **Fax:** 318-927-6714

**RE:**      **Patient Name:** HELEN SMIDDY

**DOB:** 12/8/1945    **MBI:** 5KE6NA6DU57    **PT Phone:** 3188436235

**Address:** 188 Youngblood Cir, Gibsland., LA, 71028

- ✓ **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:** 1346205507

**Phone:** 305-419-0207

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