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.**

**Treating Physician OR FNP Signature Date: 29/07/24**

**NPI:** 1881976041

**Phone: 305-419-0207**

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