

# FAX PREVIEW



## REFILL AUTHORIZATION REQUEST

Sent on 11/26/2018

124 S. GLENDALE AVE  
GLENDALE, CA 91205  
TEL: (877) 570-7787  
FAX: (877) 475-2383

PATIENT NAME	DATE OF BIRTH	PHONE	ADDRESS
Raymond Shirvanyan	01/08/2001	8181111111	111 Central Ave, Glendale, CA. 91111
PHYSICIAN NAME	PHONE	FAX	ADDRESS
*Ollivander Hemingway	8234234	899779	234 Celtic Circle, San Francisco, CA. 34534

RX NUMBER	MEDICATION	QTY	LAST FILL	DIRECTIONS	
3453453452	GABAPENTIN 300MG CAP	3		1 150mg tablet each night	<input checked="" type="checkbox"/> AUTHORIZED WITH __ ADDITIONAL REFILLS
3453453452	GABAPENTIN 300MG CAP	3		1 150mg tablet each night	<input checked="" type="checkbox"/> AUTHORIZED WITH __ ADDITIONAL REFILLS

**PLEASE CHECK ONE:****DOCTORS REMARKS:**

<input checked="" type="checkbox"/> ALL ABOVE SCRIPTS ARE AUTHORIZED FOR __ ADDITIONAL REFILLS	_____
<input type="checkbox"/> SCRIPTS ARE INDIVIDUALLY AUTHORIZED IN THE ABOVE LIST	_____
<input type="checkbox"/> NOT AUTHORIZED. PATIENT NEEDS TO CALL DOCTORS OFFICE	_____

AUTHORIZED BY

SIGNATURE

DATE

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