DONOVAN

Authorization to Complete a Specific Form

PART 1. PATIENT CONTACT INFORMATION

PATIENT FIRST NAME: _____ PATIENT LAST NAME: _____

DATE OF BIRTH: (DAY/MONTH/YEAR) : _____ _____

PATIENT ADDRESS: _____

_____

PATIENT PHONE NUMBER: _____ EMAIL _____

PART 2: How are we to submit your form?

☐ Scan and email the form back to me
☐ Mail the original signed form back to me
☐ Fax the form to my pharmacist
☐ Fax the form to the address I will provide *in part 3 below*
☐ MAIL the form to the address I will provide *in part 3 below*
☐ E-MAIL the form to the address I will provide *in part 3 below*

PART 3: What is the EXACT name, address, fax or email address we are to mail or fax the form?

EXACT NAME OF ORGANIZATION: _____

ADDRESS of ORGANIZATION: _____

_____

PHONE NUMBERS: _____ EMAIL _____

PART 4. VERIFICATION OF REQUEST

I understand that there is a fee of $ 150+Tax per completed form. I understand that these forms will be completed within 3 weeks of the date signed below. I understand that Dr. Donovan will complete these forms to the best of his ability in an honest and ethical manner and that it is possible that I may or may not completely agree with the information he has provided or the way that he has stated the information. I understand that I do have the option to discuss these forms with him at my next appointment or waive this right and simply have him proceed with filling out these forms.

_____ _____

DATE (DAY/MONTH/YEAR) SIGNATURE

PART 5: CREDIT CARD BILLING INFORMATION

NAME ON CARD: _____

CREDIT CARD NUMBER _____

EXPIRY DATE: _____ 3 DIGIT CVV CODE _____