

DONOVAN

Authorization to WRITE A LETTER ON BEHALF OF PATIENT

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 letter?

- | | |
|---|---|
| <input type="checkbox"/> Scan and email the letter back to me | <input type="checkbox"/> Fax the form to the address I will provide <u>in part 3 below</u> |
| <input type="checkbox"/> Mail the original signed letter back to me | <input type="checkbox"/> MAIL the form to the address I will provide <u>in part 3 below</u> |
| <input type="checkbox"/> Fax the letter to me | <input type="checkbox"/> E-MAIL the form to the address I will provide <u>in part 3 below</u> |

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

EXACT NAME OF ORGANIZATION: _____

ADDRESS of ORGANIZATION: _____

FAX NUMBERS _____

PHONE NUMBERS: _____ EMAIL _____

PART 4. VERIFICATION OF REQUEST

I understand that there is a fee of \$ 150+Tax per completed letter. I understand that these letters will be completed within 2 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 letters with him at my next appointment or waive this right and simply have him proceed with writing a letter on my behalf now. I understand I can also set up an appointment now to discuss what I want him to include in my letter.

DATE (DAY/MONTH/YEAR)

SIGNATURE

PART 5: CREDIT CARD BILLING INFORMATION

NAME ON CARD: _____

CREDIT CARD NUMBER _____

EXPIRY DATE: _____ 3 DIGIT CVV CODE _____