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PRESCRIPTION REFILL FAX FORM to be faxed by the practice only
 ALL AREAS MUST BE COMPLETED FOR PROPER PROCESSING

DATE: ____/____/____.

Prescribing Doctor Name as it appears on License _____ Signature _____

CLINIC Name _____ Phone # _____

<u>RX Number</u>	<u>Patient First & Last Name</u>	<u>Drug</u>	<u>Strength</u>	<u>Form</u>	<u>Qty</u>

CONFIDENTIALITY NOTICE

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