Ravi Yalamanchili M.D. P.A
Yalamanchili Brain & Spine
141 Thomas Johnson Drive, suite 200
Frederick, MD 21702
Phone: 301-846-0100 Fax 301-846-0244

PLEASE FILL OUT THE PHARMACY INFORMATION SO THE MEDICATION REFILLS CAN BE SENT ELECTRONICALLY INTO YOUR PHARMACY. IT IS THE PATIENTS RESPONSIBILITY TO INFORM THE OFFICE REGARDING ANY CHANGES. PLEASE SPECIFY IF YOUR INSURANCE REQUIRES ONLY HAND WRITTEN PRESCRIPTIONS.

PATIENT'S NAME: ____ DOB: __________________

LOCAL PHARMACY NAME: ____

PHARMACY TEL NO.:____

PHARMACY ADDRESS: ____

MAIL ORDER PHARMACY NAME: ____

PHARMACY TEL NO.: ____

OTHER: ____

ADMINISTRATIVE COMMENTS:

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, ____, date of birth ____________________

hereby authorize Doctor _______________________ to speak to the following individuals on my behalf:

NAME	RELATIONSHIP
______________________________	________________________________
______________________________	________________________________
______________________________	________________________________
______________________________	________________________________
______________________________	________________________________

Doctor________________________________ also has my permission to include information that may pertain to AIDS, ARC, HIV-related disease, blood alcohol content, and alcohol/substance abuse.

This authorization shall expire, without my express revocation on, ______________ (days or months) from the date written below. I understand that I have the right to withdraw this authorization at any time except to the extent that action has been taken based on this authorization.

______________________________________ ____________________

Signature of Patient or Guardian Date

____

Printed name and relationship of guardian

____

Witness