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HIPAA COMPLIANT CONFIRMATION FORM TO CONFIRM AN ACTIVE PATIENT PURSUANT TO 45 CFR 164.508

PATIENT INFORMATION

Name: JOSEPH QUATTRONE	ID: 1R11CD6UK18
Birth Date: 2/10/1934	Phone: 3012924024
Address: 12815 GLYNIS RD , - CLINTON MD 20735	

PROVIDER'S INFORMATION

Name: Dr. Lalitha Vedantam, MD	NPI: 1942618996
Practice Address: 11701 LIVINGSTON RD # SUI101 FORT WASHINGTON MD 20744	Phone: 8325514093

(FOR PROVIDER'S USE ONLY)

I confirm that:

- **This patient is / was under my care at this office.**
- **If the patient has changed or switched to another Provider, please mention below.**
- **I undersigned; confirm that the above patient is / was under my care. I confirm that this information is correct.**

NOTE: MUST BE A PHYSICAL SIGNATURE WITH CLINICAL STAMP OR DOCTOR STAMP.

Provider's confirmation signature: _____

Date: 02/18/22

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NOTE: MUST BE A PHYSICAL SIGNATURE WITH CLINICAL STAMP OR DOCTOR STAMP.

Provider's confirmation signature: _____

Date: 1/19/22

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