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

PATIENT INFORMATION

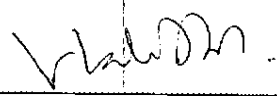
Name: JOSEPH QUATTRONE	ID: 1R11CD6UK18
Birth Date: 2/10/1934	Phone: 3012924024
Address: 12815 GLYNIS RD , - CLINTON MD 20735	

PROVIDER'S INFORMATION

Name: Dr. Lalitha Vedantam, MD	NPI: 1942618996
Practice Address: 11701 LIVINGSTON RD # SU101 FORT WASHINGTON MD 20744	Phone: 8325514093

(FOR PROVIDER'S USE ONLY)**I confirm that:**

- ☒ This patient ☒ 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**FAX BACK TO: 867-670-1366**

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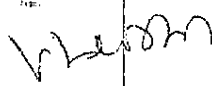
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NOTE: MUST BE A PHYSICAL SIGNATURE WITH CLINICAL STAMP OR DOCTOR STAMP.Provider's confirmation signature: Date: 2/19/22**FAX BACK TO: 867-670-1366**

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