

Porter Pharmacy

308 W. Larissa St
Jacksonville, TX 75766
(903) 586-9804

CUSTOMER REQUEST FOR MEDICAL EXPENSE STATEMENT & RELEASE OF INFORMATION

Name: _____

DOB: _____

Address: _____

Phone: _____

I, _____, request that Porter Pharmacy provide a Medical Expense Statement (MES) for the individuals listed below.

I understand that Porter Pharmacy may only release an MES pertaining to my records, the records of my dependents, or the records of individuals for whom I am a personal representative in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Individual Information:

Patient Name	Date of Birth	Relationship	Date Range of Records Requested
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Authorization Requirement: I understand that requests for individuals other than those listed above (such as a spouse) will require either (1) the submission of separate MES request signed by the individual, or (2) a valid authorization signed by that individual and attached to this form.

Release of Information

I authorize the following individuals access to my records and to speak with the staff members of Porter Pharmacy:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Verification of Identity: _____ Known Individual
_____ Driver's License (_____)
_____ Other ID, (specify) _____

Signature of Customer or Personal Representative

Date

If Signed by the patient's personal representative, the representative warrants that he or she has authority to sign this form on the basis of documentation: (attach a copy of any documentation used to verify authority).