Itemized Bill Request Form

This authorization permits **Total Point Urgent care** *(as such term is defined by HIPAA and applicable Texas law)* to use or disclose an individual's protected health information.

Individuals completing this itemized bill request form should read and complete all sections of this form in its entirety before signing.

If you are completing this for someone other than yourself, you will need to also complete the 'Authorization to Use or Disclose Protected Health Information' form. Should you have any questions or need assistance completing this form, please call our center at 866-439-3165

Please keep in mind under HIPPA 45 CFR. 164.524 Law we are allowed 30 calendar days to complete your request.

Requester First and Last name: _____

Patient First and Last name: _____

Relationship to Patient:

O Self O Parent/Legal Guardian O Spouse O Other: _____

Last four digits of patient's Social Security Number: _____

Patient's Date of Birth: _____

Date of service (date you are requesting the Itemized bill for): _____

Where do you want your Itemized bill sent to: (select an option below)

O Mailed to home:

Mailing Address: _____

O Pick up at Facility:

Location visited: _____

Signature and Date:

_____