**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 469.409.1472

**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**: