This form is produced in Microsoft Word version 7 format . Please fill this form out and forward it to **drkline@bpimc.com** or **fax it to 732-329-5668**.

Brunswick Princeton Family Practice Medication Refill Request Form

1. Please fill out all details of this form. Accuracy, completeness and correctness is important
2. Fax, e-mail, or hand deliver the form back to us

Today's Date: ______________________

Patient Name: ____

Patient Social Security #: ________/________/________ Patient Date of Birth: ____/____/________

Insurance Company Name: __________________________________ cell phone number: _____________________________

Home telephone number ________________________ work telephone number ________________________

Name of medication (please be sure this is spelled correctly, look at your bottle) ____________________________

dose of medication(# of mg, drops etc with each use)____

frequency of use (daily, two times per day etc) ____

Pharmacy name, along with town and St.; (ex: xyz pharmacy, route one, south brunswick)

____

Pharmacy telephone number: ____

You must sign a statement (if you fax) or attested (if you e-mail) for us to accept and respond to your e-mails:

I understand that e-mail is not secure. Nonetheless, I want Bradley H. Kline, D.O. to respond to my e-mails via an e-mail response. I further declare and assert that I take full responsibility, hold harmless and indemnify Dr. Kline if someone taps into our communication and in this way gains personal information concerning me, my healthcare, or any other personal and or confidential information. I further hold Bradley H. Kline, D.O. harmless and indemnify him, if by responding to me via e-mail, he violates any provisions, statues, or terms of the health care insurance and portability act, otherwise known as HIPPA.

DO NOT send e-mails for urgent matters. E-mails will be check within 4 business days.

I have read and understand the hippa statement from Dr Kline's office.

X____ Date_________________