

**SAMPLE  
MEDICAL PRACTITIONER EXPENSES VERIFICATION**

To: \_\_\_\_\_ From: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

RE: \_\_\_\_\_ Unit # \_\_\_\_\_ S S # \_\_\_\_\_

**HOUSEHOLD MEMBER RELEASE**

TO THE HOUSEHOLD MEMBER: YOU DO NOT HAVE TO SIGN THIS FORM IF THE NAME OR ADDRESS OF EITHER THE PROJECT OR PROVIDER IS LEFT BLANK.  
RELEASE: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances which would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The household member named above has applied for, or is recertifying eligibility for housing financed or assisted by the Federal or State Government. The housing owner is required to verify all information that is used in determining the person's eligibility or level of benefits.

Your prompt return of this form to the project listed above will help to ensure timely processing of the assistance application.

The information requested covers the following dates from \_\_\_\_\_ to \_\_\_\_\_

Number of visits during the LAST twelve months \_\_\_\_\_

Total out-of-pocket paid by client during the LAST twelve months \$ \_\_\_\_\_

Number of visits anticipated during the NEXT twelve months \_\_\_\_\_

Total out-of-pocket anticipated to be paid by client in the NEXT twelve months \$ \_\_\_\_\_

\*IF SUBMITTING A PRINT OUT PLEASE EXCLUDE THE NAMES OF DOCTORS AND MEDICATIONS. THE PRINT OUT MUST INDICATE "OUT OF POCKET" EXPENSES FOR THE PARTY OR PARTIES LISTED ABOVE AND BE SIGNED BY THE PHARMACIST.

Account balance the client is responsible for \$ \_\_\_\_\_

Does the client make regular monthly payments?  Yes  No If yes, amount of monthly payments: \$ \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

I certify that the above information is true and correct.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name and Title

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Date

**PENALTIES FOR MISUSING THIS VERIFICATION**

Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government, HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than \$5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty Provisions for misusing the social security number are contained in the Social Security Act at \*\* 208 (a) (6), (7) and (8).\*\* Violation of these provisions are cited as violations of 42 U.S.C. Section \*\* 408 (a) (6), (7) and (8).\*\*

