

Liberty Mail Meds

Mail to Us
Liberty Mail Meds
 8397 Northcliffe Blvd
 Spring Hill, FL 34606

1. Get Prices

Call for a price quote on your medications and then fill out the form below.

2. Place Your Order

Send the completed form to us along with a copy of your prescriptions.

3. Receive Your Order

Medications will arrive at your door within 7—10 days

Call Us Toll-Free 1-800-655-8185

Fax Us Toll-Free 1-877-515-5552

Ask about Diabetic Supplies, Alternative Health Products, and Pet Medications

Bill to:

Patient Name _____

Address _____

Apt # _____ Phone _____

City _____

State _____ Zip Code _____

Ship to: (If Different)

Patient Name _____

Address _____

Apt # _____ Phone _____

City _____

State _____ Zip Code _____

Date of Birth _____

Height _____ Weight _____

Physicians Name _____

Phone # _____

Drug Allergies (If any) _____

Drug Name (Indicate if generics are acceptable)	Generics Yes / No	Dosage Mg / Ml	Qty	Price

Payment Method: Visa _____ MC _____

Exp. Date ____/____/____ CVV2# _____

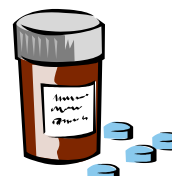
Card # ____/____/____/____

Cardholder Printed Name _____

Cardholder Signature _____

Shipping Charges !
 \$15.00 From International Suppliers
 \$5.95 From US Suppliers

Subtotal
Shipping
Total



MEDICAL HISTORY QUESTIONNAIRE

Has customer seen their physician in the past 12 months? Yes No

- | | |
|--|---|
| <input type="checkbox"/> Blood Diseases | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Immune Systems Disorders | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Hormone Disorders |
| <input type="checkbox"/> Nutritional, Mineral or Electrolyte Imbalance | <input type="checkbox"/> Lipid or Cholesterol Disorders |
| <input type="checkbox"/> Heart/Circulatory Disease | <input type="checkbox"/> Kidney/Urinary Disease |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Orthopedic or Muscle Disease |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Surgical Procedures |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Additions (chemical) |
| <input type="checkbox"/> Airway Disease | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Arthritis, Lupus |
| <input type="checkbox"/> Poor Wound Healing | |

Other Conditions _____

Additional Medications Taken: _____

AUTHORIZATION AND CONSENT

1. I hereby authorize and appoint Liberty Mail Meds (LMM) as my agent for the limited purpose of assisting me in obtaining prescription medications.
2. I hereby specifically acknowledge that I am aware that LMM, and the Prescription Processing Centre, will be transmitting my personal health information by electronic means (for example fax, secure internet) to its employees, agents', and service providers and if necessary a physician retained on my behalf. I understand that the use of electronic means will enhance the efficiency and timeliness of processing my order. I also understand the LMM and the Prescription Processing Centre, as custodians of my personal health information, will take all appropriate precautions to protect my personal health information from improper disclosure or use. I hereby consent to the transmission, by LMM and the Prescription Processing Centre, of my personal health information by electronic means.
3. I hereby give any doctor retained on my behalf authority to contact my physician for more information regarding my medical conditions or prescriptions, if required. I hereby give permission to my physician to release my medical files and medical reports as needed to obtain sufficient information for the purpose of prescribing my medications.
4. I understand that I must have a valid prescription from my doctor before LMM will provide medication. I also understand that no controlled medications or narcotics, or other medications that the physician or pharmacist decides are inappropriate, will be dispensed. I understand that LMM will always substitute a generic drug, when available, for a brand name drug unless I have decided otherwise.
5. I understand that if I have medical insurance in the United States, my insurer may not reimburse me for prescription medications that come from International suppliers. My signature below indicates that I have read the above release and agree with its terms and conditions.

Patient Printed Name

Patient or Authorized Signature

Date