James R. Bond, Jr., M.D., P.A.
1615 Lancaster Drive, Suite 107
Grapevine, TX 76051
817-488-55555 Fax: 817-421-0400

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I hereby authorize **Dr. James Bond, Jr.** to release health records information on:

Patient Name: _____ _____ Date of Birth: _____

Address: _____ Soc. Security #: _____

_____ Telephone: _____

For healthcare covering the period(s) from_____ to _____ _____

Name of person to receive information:

Name: _____ Telephone#: _____

Address:_____

I __do __do not authorize this information to be faxed. If yes, fax # _____.

Name of person to receive information:_____.

This information is being disclosed for the following purpose(s) of: _____.

I understand that if I request copies of records myself or for a member of my family, a review of the information with my physician or healthcare provider is encouraged. . I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein. Information to be disclosed:

_____Complete Health Record _____Progress Note _____Billing Records _____Other

I understand this information may contain information regarding to: (check if applicable)

____Acquired Immunodeficiency Syndrome(AIDS) ____Mental Health _____Alcohol and/or drug abuse

_____or infection with HIV (Human Immunodeficiency Virus)

REVOCATION: I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposed stated above. Unless otherwise indicated, this authorization will expire ninety (90) days from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that there is a ***$6.50 fee*** for preparing and furnishing this information.

_____ _____ _____

Signature of Patient or Legal Representative Relationship Date