James R Bond, Jr., M.D., P.A.
1615 Lancaster, Drive Suite 107
Grapevine, TX 76051
817-488-5555
Fax: 817-421-0400

Disclosure of Medical/Financial Information to Friends or Family
(For Patients 18 years and older)

Name of Patient: _____

Date of Birth: _____ Phone Number: _____

Email: _____

I, the undersigned, hereby authorize Dr. James R. Bond, Jr. and staff to disclose information from my medical or financial record to the following people:

Name: _____ Relationship: _____

Phone Number: _____

Type of information (circle): Medical Financial Both

_____

Name: _____Relationship: _____

Phone Number: _____

Type of Information (circle): Medical Financial Both

This authorization is given freely with the understanding that:

1. This authorization is valid between January through December of year signed.
2. May revoked in writing at any time but not retroactively.
3. The facility, its employees, officers, and physician are hereby released from any legal responsibility of liability for disclosure of the information I authorized previously.

_____ _____

Patient Signature or Authorized Representative Date