

JAMES R. BOND, JR., M.D., P.A.

DERMATOLOGY
BAYLOR MEDICAL CENTER - GRAPEVINE
1600 W. COLLEGE
SUITE 490
GRAPEVINE, TEXAS 76051

817/488-5555

METRO: 817/329-2222

FAX: 817/421-0400

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I hereby authorize Dr. James R. 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 _____ Other healthcare provider records (specify): _____

TO:

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 give permission to give my lab or path results to: _____

I understand that if I request copies of records for myself or for a member of my family, a review of this information with my physician or other 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 notes Billing records Other

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

Acquired Immunodeficiency Syndrome (AIDS), or infection with HIV (Human Immunodeficiency Virus),

Mental health Alcohol and/or drug abuse

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 purposes 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 may be a fee for preparing and furnishing this information.

Signature of Patient or Legal Representative

Relationship

Date