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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 ___ or 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 if I request copies of records for myself or for a member of my family, a review of the information with my physician or other healthcare provider is encouraged. I understand 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) ___ Mental Health ___ Alcohol and/or Drug Abuse
___ Human Immunodeficiency Virus (HIV)

REVOCATION: I understand 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 there may be a fee for preparing and furnishing this information.

Signature of Patient or
Legal Representative

Relationship

Date