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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 _____

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 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