James R Bond, Jr., M.D., P.A.
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Disclosure of Medical/Financial Information to Friends or Family
(For Patients 18 years and older)

Name of Patient: ____

Date of Birth: ____________________ Phone Number: ____________________

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