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

DERMATOLOGY
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, the undersigned hereby authorize:

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to release the information specified below:

_____ Office Visits
_____ Pathology Reports
_____ Laboratory
_____ Billing Records
_____ All Records

to:

James R. Bond, Jr., M.D., P.A.
1615 Lancaster Drive
Suite 107
Grapevine, TX 76051

The reason for release of this information is: _____
I understand that this authorization will expire in 90 (ninety) days from the date of signature. I understand that this information may contain sensitive information (STD, HIV/AIDS, etc.) This authorization may be cancelled anytime when the provider receives my notice in writing.

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

_____