BOND CLINIC, P.A.

PLEASE READ BOTH PAGES THOROUGHLY BEFORE SIGNING

Please be aware that you will receive a bill from Bond Clinic, PA. The fees we charge per Florida Legislature are as follows:

Patients and Governmental Entities:

- $1.00 per page 1-25
- $0.25 per page for each page thereafter
- Plus postage and tax

All other Entities:

- $1.00 per page
- Plus postage and tax

If you have any questions regarding Bond Clinic, PA billing, please contact the Patient Accounting Department at (863) 293-1191 ext 3356 or 3357.

I acknowledge that I will receive a statement directly from Bond Clinic, PA.

***BY SIGNING THIS AGREEMENT, I HEREBY ACKNOWLEDGE, I WILL BE RESPONSIBLE FOR ANY CHARGES FOR REPRODUCTION OF MY MEDICAL RECORDS.**

X_____
Signature of Patient/Requestor

Date: _____

X_____
Witness / Bond Clinic Representative

For Office Use

Patient Name: _____

Medical Record Number: _____

Release of Protected Health
Information Authorization Form

BOND CLINIC, P.A.
500 EAST CENTRAL AVE.
WINTER HAVEN, FL 33880
(863) 293-1191

MEDICAL RECORD #:_____

PATIENT NAME: _____**DATE OF BIRTH:** _____

PATIENT ADDRESS: _____**SS#:**_____

PHONE NUMBER: _____ **PHYSICIAN:** _____

I hereby authorize the use or disclosure of my individually, identifiable protected health information about me as described below. I understand that this authorization is voluntary. This release includes sexually transmitted disease record, TB records, HIV & AIDS related information, and drug/alcohol records, psychiatric/psychological information/records, adult and child abuse information, and/or abortion information records, unless specifically listed below under exclusions:

Chart Abstract: (specify which physician(s) and date of service/office visit date or date range):
_____

Diagnostic Report (specify test date and type of test i.e. lab or x-ray): _____

Exclusions (specify as described above): _____

Radiology Film(s) (specify exam type and date): _____

PURPOSE OF DISCLOSURE: _____
I hereby release Bond Clinic, P.A. and it employees, agents, officers, and affiliates from any and all liability, responsibility, claims and damages which may result from the release of information authorized by this authorization.

RELEASE INFORMATION FROM (Physician/Provider name):_____

PHYSICIAN'S ADDRESS:_____

PHYSICIAN'S PHONE #:_____

PHYSICIAN'S FAX #: _____

RELEASE INFORMATION TO (Physician/Provider name):_____

PHYSICIAN'S ADDRESS: _____

PHYSICIAN'S PHONE: _____

PHYSICIAN'S FAX #: _____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. I may revoke this authorization by notifying Bond Clinic, P.A.'s Privacy Contact in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. This authorization shall automatically expire (90) ninety days from the date set forth below, or upon the following date, event or condition: _____

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for copies; if not, then the copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____ _____ _____
Signature of Patient, Guardian, or Personal Representative **Date** **Relationship**

Witness Signature_____ **Date**_____