William R Bond, Jr, M.D. LLC

OTOLARYNGOLOGY (ENT) HEAD &NECK SURGEON

Records Release/Request

To: _____

Address: _____

City: _____State _____Zip: _____

I hereby authorize the release of a copy of my medical record, and request that it be transferred to:

Dr. William R Bond, Jr.
106 Irving Street, N.W., Suite 312
Washington, D.C. 20010
202.726.7770 Phone
202.726.7702 Fax

Date of Records

FROM: _____TO: _____

Print Patient's Name _____DOB: _____

Patient's Signature _____
If not 18 years of age or older, Parent or Legal Guardian's signature

Date: _____

Physician's Signature: _____