Dr. J. Michael Fite, M.D.
1125 South Henderson
Fort Worth, TX 76104

Patient Name**: _____**

I hereby authorize employees and agents; including physician and nurse: of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders to the physicians; including consultants, associates, and assistants of the physicians' choice.

If patient is a minor:
I consent for _____to authorize evaluation and treatment for my child
(Name: First and Last)
herein when I am not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures and immunizations for the child herein.

The duration of this consent is indefinite and continues until revoked in writing,
I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Signature of Patient of Legal Guardian Date

_____

I hereby authorize payment of medical benefits directly to the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record to my medical insurance company (or its employees or agents) as may be necessary to process and complete my medical insurance claim. I understand that this medical authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS ") and human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Dr. J. Michael Fite. I further understand should any account become delinquent; I shall pay the reasonable attorney fees or collection expenses if any.

The duration of this authorization is definite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible of services in full before the services are rendered.

Signature of Patient of Legal Guardian Date

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