COMMUNICATION AUTHORIZATION & RELEASE OF INFORMATION TO FAMILY MEMBERS OR OTHER INDIVIDUALS

PATIENT:_______________________________________DATE OF BIRTH:____________________

Please indicate below the names and relationship of any individual John L. Fewins, MD and/or his staff may discuss your healthcare issues with. This authorization and release includes information communicated via phone, mail, email, fax, or in person.

Name/Relationship: ____

Phone Number: ____

Name/Relationship: ____

Phone Number: ____

Name/Relationship: ____

Phone Number: ____

Name/Relationship: ____

Phone Number: ____

Name/Relationship: ____

Phone Number: ____

For patients with a guardian, please provide the guardian's name and authority.

Name: ____

Description: ____
Of Authority
Parent, Legal Guardian, Power of Attorney, Court Ordered Guardian, etc.

PATIENT/GUARDIAN: ____DATE:__________
SIGNATURE

Please provide written notification to revoke this authorization to: John L. Fewins, MD, 800 8th Ave, Suite 336, Fort Worth, TX 76104