

Wesley T. Myers, M.D. P.A.

PLASTIC & RECONSTRUCTIVE SURGERY

100 Medical Center Blvd, Suite 213, Conroe, TX 77304

PH – 936-539-8115 FAX – 936-539-8118

**PATIENT AUTHORIZATION  
TO RELEASE  
PROTECTED HEALTH INFORMATION  
TO DESIGNATED REPRESENTATIVE(S)**

I, \_\_\_\_\_, give my authorization to release my protected health information including results of my laboratory tests, x-ray and/or other test results to the following designated representative(s):

Patient Initials

\_\_\_\_\_ My spouse (Name) \_\_\_\_\_

\_\_\_\_\_ My child (Name) \_\_\_\_\_

\_\_\_\_\_ Other (Name) \_\_\_\_\_

\_\_\_\_\_ Personal Representative \_\_\_\_\_

\_\_\_\_\_ May be left on my answering machine at home.

\_\_\_\_\_ May be left on my answering machine at work.

\_\_\_\_\_ MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

***As a patient, you have the right to revoke this authorization in writing at anytime, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Wesley T. Myers, MD PA must receive the revocation in writing. The revocation must include, 1) the patient's name, address, and date of birth, 2) the patient's desire to revoke the authorization, and 3) the date of the revocation and the patient's signature. All revocations must be sent in writing to the attention of Wesley T. Myers, MD PA at 100 Medical Center Blvd. Conroe, TX, 77304 or faxed to (936) 539-8118 and will not be considered effective until received by Wesley T. Myers, MD PA.***