Wesley T. Myers, M.D. P.A.
PLASTIC & RECONSTRUCTIVE SURGERY
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GUARDIAN/MINOR CHILD AUTHORIZATION
TO RELEASE
PROTECTED HEALTH INFORMATION
TO DESIGNATED REPRESENTATIVE(S)

I, _____, the named legal guardian(s) of _____ (minor child) give permission to release 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 relative (Name) _____

_____ Other (Name) _____

_____ 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.

_____ _____
Guardian's 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, Sadler Clinic 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 Sadler Clinic's Privacy Officer at 9201 Pinecroft Drive, The Woodlands, TX, 77381 or faxed to (281) 297-6481 and will not be considered effective until received by the Privacy Officer.