PLEASE PRINT

Patient Name_____

DOB_____

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