PLEASE PRINT

Patient Name_____

DOB_____

Wesley T. Myers, M.D. P.A.
Plastic & Reconstructive Surgery
100 Medical Center Blvd., Suite 213
Conroe, TX 77304
Ph: 936-539-8115 FX: 936-539-8118

AUTHORIZATION FOR RELEASE OF PATIENT PHOTOGRAPH

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of the Wesley T. Myers, M.D. P.A. medical staff. I hereby give my consent for Wesley T. Myers, M.D. P.A. to use the photographs under one of the following circumstances.
Please initial one of the following:

_____ **Internet:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Wesley T. Myers, M.D. P.A., can be used on the company's website in order to inform the public about plastic surgery methods. Further, I release and discharge Wesley T. Myers, M.D. P.A., any employees of Wesley T. Myers, M.D. P.A., and the American Society of Plastic Surgeons; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during any use or publication of these materials by any party.

_____ **All Media:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Wesley T. Myers, M.D. P.A., can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet, and television, in order to inform the public about plastic surgery methods. Further, I release and discharge Wesley T. Myers, M.D. P.A., any employees of Wesley T. Myers, M.D. P.A., and the American Society of Plastic Surgeons; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

_____ **Medical Care Only:** Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Wesley T. Myers, M.D. P.A. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Wesley T. Myers, M.D. P.A.

_____ _____
Signature Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____, a minor. I am authorized to sign this authorization oh his/her behalf and I give this authorization as voluntary contribution in the interest of public education.

_____ _____
Signature Date

_____ _____
Witness Date