Bryan Weckel, M.D. Family Medicine
P.O Box 1266 / 310 South Bennett St.
Burgaw NC 28425
Phone (910)259-1718 Fax (910)259-9929

I hereby authorize Bryan Weckel, M.D. Family Medicine to request/release a copy or copies of the specific health and medical information described below regarding:

Name of Patient:_____
DOB:_____ BWFM Chart #:_____

From/To:
Bryan Weckel, M.D. Family Medicine
P.O. Box 1266 / 310 South Bennett St
Burgaw NC 28425

From/To:
_____
_____
_____
_____

Information requested or information to be used/disclosed:

- ❑ All records
- ❑ Records from (date)_____ To _____
- ❑ Other:_____

Purpose of Disclosure:

- ❑ Continuation of medical care
- ❑ Other:_____

If we are requesting this authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this authorization; and
- We must provide you with a copy of the signed authorization.

I understand and acknowledge that this authorization may include consent for release of alcohol/drug abuse, mental health, pregnancy, sexually transmitted diseases, or HIV/AIDS information.

You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization. Unless revoked earlier or otherwise indicated, this authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Patient/Patient Representative Signature and Date:_____

Patient Representative Authority/Relationship:_____

Witness signature:_____