WILMINGTON GASTROENTEROLOGY ASSOCIATES

5115 Oleander Drive
Wilmington, NC 28403
Phone: (910) 362-1011
Fax: (910) 392-1316
Attn: MEDICAL RECORDS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION **WGA chart #:_____**

_____ _____/_____/_____
First Middle Initial Last Date of Birth

SS #: XXX-XX-_____

STAT □
CHECK IF URGENT

You need an office appointment/procedure in _____ with _____MD/PA
Once we receive records, your appointment will be scheduled.

TO / FROM:

_____/_____
(Physician Name) **(city/state)** **(phone #)** **(fax #)**

_____/_____
(Physician Name) **(city/state)** **(phone #)** **(fax #)**

_____/_____
(Physician Name) **(city/state)** **(phone #)** **(fax #)**

To / From:	**Clinton Meyer MD**	**Jean Nichols PA-C**	**Taylor Thompson PA-C**
	Joseph Kittinger MD	**Heather Goldstein PA-C**	**Sarah Rydock PA-C**
	William King MD	**Wendy Landrigan PA-C**	**Justin Toth PA-C**
	Robert Henihan MD	**Jennifer Preston PA-C**	
	Steven Klein MD	**Stacey Pennington PA-C**	
	D. Spencer Carney MD	**Lesley Nevenzel PA-C**	
	Mary Sauer MD		
	Kunal Dalal MD		

Purpose of Disclosure: Continuity of Medical Care

Records Requested: (please **check** & **circle** below to indicate documents requested w/ date of test, if known)

- □ Colonoscopy, EGD, ERCP, Flex Sigm Reports done: (dates) _____
- □ Endoscopy Pathology/Histology Results done: (dates) _____
- □ Laboratory results/dates:_____
- □ X-Ray reports: CT scan_____, Ultrasound_____, MRI abd._____, UGI_____, BaSw_____, Modified BaSw_____,SBFT_____, HIDA Scan_____, GES_____, Other_____
- □ Liver Biopsy results done: (date)_____
- □ Office Notes, Medication List, Any Vaccination records
- □ Hospital reports: History/Physical _____; Consult note_____; D/C note_____
- □ Other (list) : _____

In signing below, I hereby authorize the release of my health information. I give my permission for the information listed above to be released to the above named requestor. I understand and acknowledge that this may include alcohol/drug abuse, mental health, Hepatitis, or HIV/AIDS information. This request will expire in one year of date signed. I may revoke this authorization at any time, except to the extent that action has already been taken to comply with the request.

Date:_____ **Signature:_____**
(Patient or Legal Representative)

Initials of Sender: _____ * *COPY GIVEN TO PATIENT _____

Please contact *it@wilmingtongi.com* to obtain the Direct Message addresses for our providers to be able to send secure messages directly to our EMR system to efficiently continue patient care.

REV 4/17