



**WILMINGTON GASTROENTEROLOGY
ASSOCIATES**

5115 Oleander Drive
Wilmington, NC 28403
Phone: (910) 362-1011

Fax: (910) 362-1012 Attn: MEDICAL RECORDS

WGA chart #: _____ AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

SS #: XXX-XX-

SEND **STAT** or You need an office appointment/procedure in _____ with _____ MD/PA.
(circle one) Once we receive records, your appointment will be scheduled.

I hereby authorize the release of my health information. This will expire in one (1) year of date signed.

To / From: _____ / _____
(physician name) (address) (phone #) (fax#)
_____/_____
(physician name) (address) (phone #) (fax#)
_____/_____
(physician name) (address) (phone #) (fax#)

To / From: Clinton Meyer MD Jean Nichols PA-C Taylor Huckabee, PA-C
Joseph Kittinger MD Heather Goldstein PA-C Janice Bridges, PA-C
William King MD Wendy Hudson, PA-C Justin Toth, PA-C
Robert Henihan MD Jennifer Preston, PA-C Sarah Rydock, PA-C
Steven Klein MD Stacey Pennington, PA-C
D. Spencer Carney, MD Lesley Cassetto, PA-C
Mary Sauer, MD

I understand and acknowledge that this may include alcohol/drug abuse, mental health, Hepatitis, or HIV/AIDS information.

Purpose of Disclosure: Continuing Medical Care

Information Requested: (check and circle what requested with date of test, if known)

- Colonoscopy, EGD, ERCP, Flex Sigm Reports done: (dates) _____
- Endoscopy Pathology /Histology Results done: (dates) _____
- Laboratory results /dates: _____
- X-Ray report/s: 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) : _____

I give my permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. ****COPY GIVEN TO PATIENT** _____

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

Initials of Sender: _____ Witness: _____