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:

Joseph Kittinger MD
William King MD
Robert Henihan MD
Steven Klein MD
D. Spencer Carney MD
Mary Sauer MD
Kunal Dalal MD

Jean Nichols PA-C
Heather Goldstein PA-C
Wendy Landrigan PA-C
Jennifer Preston PA-C
Lesley Nevenzel PA-C
Justin Toth PA-C

Sarah Rydock PA-C
Rheanna McKnight, PA-C
Darah Wenzowski, PA-C

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 4/18