**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**
**Stacey Pennington PA-C**
**Lesley Nevenzel PA-C**

**Justin Toth PA-C**
**Sarah Rydock PA-C**
**Kate Wilson PA-C**
**Rheanna McKnight 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.**