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:
William King MD
Robert Henihan MD
Steven Klein MD
D. Spencer Carney MD
Mary Sauer MD
Kunal Dalal MD
Justin Miller, MD
Russell Dolan, 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 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. ***The requested medical records are for continuity of medical care as noted; The HIPAA Privacy Rule permits a health care provider to disclose protected health information about an individual, without the individual's authorization, to another health care provider for that provider's treatment of the individual****. See 45 CFR 164.506 and the definition of "treatment" at 45 CFR 164.501 Refer to the Office for Civil Rights at HHS.gov*

Date:_____ Signature of Patient/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 4/22