J. Eugene McMurry, Jr., M.D., F.A.C.S.
S. Elizabeth vonBiberstein, M.D., F.A.C.S.
George M. Brinson, M.D.
Stuart M. Hardy, M.D.
Janet C. Bogus, Ph.D., F-AAA, CCC-A
Julie Grgurevic, M.S., F-AAA, CCC-A
Julie L. Miller, M.A., F-AAA

WILMINGTON
EAR NOSE & THROAT
ASSOCIATES

MAIN OFFICE:
2311 Delaney Avenue
Wilmington, NC 28403
Phone: 910-762-8754
Fax: 910-762-0778

PORTERS NECK OFFICE:
8068 Market Street
Wilmington, NC 28411
Phone 910-681-1488
Fax 910-681-1490
www.wilmingtonent.com

Patient ID #: _____

Dr#: _____

Authorization to Release Records
(From Wilmington Ear Nose & Throat Associates)

Patient Name: _____/ _____/ _____
(PRINT) First Name Middle Initial Last Name

DOB: _____ Pease provide current phone #: _____

I have signed and approved for copies of my (or minor child/guardian adult) individual medical health record (identity noted above) to be RELEASED by fax, or mail to the following medical practice/medical facility/other entity, or SELF.

TO:
FROM: Name: _____

Address: _____

Phone#: _____/ Fax#: _____
(Most important, please)

TO:
FROM: Wilmington Ear Nose &Throat Associates *2311 Delaney Ave Wilmington, NC 28403 *ph#:910.762.8754; fax#:910.762.0778

Check One:
_____ Any and all parts of my medical records, which may include documentation related to HIV/AIDS, psychiatric care, sexually transmitted diseases, and/or treatment of alcohol/drug abuse.
_____ Any part of my medical record only for the time period of _____ to _____ including data related to HIV/AIDS, psychiatric care, sexually diseases, &/or treatment of alcohol/drug abuse.
_____ Only For the release of Specific Information: _____

I hereby authorize the release/disclosure of my (or minor child) medical health record as checked above. I understand that this request" is voluntary. I understand that any Re-disclosure of records provided to/ used by the "patient/ or authorized signature below", (to any entity, at any time) may no longer be protected by Federal Privacy Regulations/HIPPA. The employees and Physicians of WENTA, PA, are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized in this release.

Patient's Signature: _____ Date: _____

Parent/ Guardian/Power of Attorney Signature: _____ Date: _____

(Documentation must be provided (if not in the record) for: Power of Attorney/Legal Guardianship/Court Custody/Adoption)