S. Elizabeth vonBiberstein, M.D., F.A.C.S. George M. Brinson, M.D. Stuart M. Hardy, M.D. E. Burke Haywood, Jr. M.D. Micaela Antzoulatos, PA-C Alexandria Lee, Au.D., CCC-A Casey Behre, Au.D. CCC-A Meghan Westman, Au.D. CCC-A Kyndell Belcher, Au.D., CCA-A



MAIN OFFICE:

2311 Delaney Avenue Wilmington, NC 28403-6012

Phone: 910-762-8754 Fax: 910-762-0778

Patient ID #: _			
Dr#:			
	A	Authorization to Release	e Records
	(From '	Wilmington Ear Nose & Tl	nroat Associates)
Patient Name:		/	
(PRINT)	First Name	Middle Initial	Last Name
DOB:	Please provide current phone #:		
•		•	dult) individual medical health record (identity al practice/medical facility/other entity, or SELF.
TO:			
FROM:	Name:		
	Address:		
	Phone#:		/Fax#:
TO:	(Most important, ple	ease)	
FROM:	Wilmington Ear Nose &Throat Associates 2311 Delaney Ave Wilmington, NC 28403 phone#:910.762.8754 fax#:910.762.0778		
Check One:	r		
sexually transi	mitted diseases, and/or treatr	ment of alcohol/drug abuse.	ocumentation related to HIV/AIDS, psychiatric care,
			, &/or treatment of alcohol/drug abuse.
_			, &/of treatment of alcohol/drug abuse.
I hereby authorist voluntary. I uentity, at any time	ize the release/disclosure of my inderstand that any <u>Re-disclosu</u> me) may no longer be protected released from any legal respons	y (or minor child) medical health are of records provided to/ used d by Federal Privacy Regulation	by the "patient/ or authorized signature below", (to any s/HIPPA. The employees and Physicians of WENTA, e of the above information to the extent indicated and
Patient's Signa	ature:		Date:

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

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