

**Authorization for Release of Information**

Fax to: 309-268-3213 or

Mail to:

Advocate Medical Group  
ENT Surgical Associates of Central Illinois  
207 Landmark Drive, Normal, IL 61761

Willard S Noyes, MD  
Thomas C Kelly, MD

PH: 309-268-3200  
FAX: 309-268-3213

**PLEASE PRINT OR TYPE:**

Authorization is given to:

**Release records to: ENT Surgical Associates of Central Illinois** Willard S Noyes, MD, Thomas C Kelly, MD

Patient information on (full name): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Dates of service: \_\_\_\_\_

Type of service:  Inpatient  Outpatient

For the purpose of:  Continuation of Care  Other: \_\_\_\_\_

We are requesting any of the following, an additional authorization from the patient may be necessary:

- Release of psychiatric information?  Yes  No
- Release of chemical dependency information?  Yes  No
- Release of AIDS information?  Yes  No
- Release of genetic information?  Yes  No

**The following information is requested:**

- |   |   |
|---|---|
| <input type="checkbox"/> Face Sheet                     | <input type="checkbox"/> EEG/EMG  |
| <input type="checkbox"/> ER Records                     | <input type="checkbox"/> Operative Report                               |
| <input type="checkbox"/> Discharge Summary              | <input type="checkbox"/> Pathology Report                               |
| <input type="checkbox"/> History and Physical           | <input type="checkbox"/> Progress Notes - Physicians                    |
| <input type="checkbox"/> Consultation                   | <input type="checkbox"/> Progress Notes - Nurses                        |
| <input type="checkbox"/> Laboratory                     | <input type="checkbox"/> Discharge Summary - Counselor                  |
| <input type="checkbox"/> HIV test results               | <input type="checkbox"/> Nurses' Assessment - History                   |
| <input type="checkbox"/> EKG, Echo, Holter, Stress Test | <input type="checkbox"/> Physical, Occupational, Speech Therapy Records |
| <input type="checkbox"/> Audiology report               | <input type="checkbox"/> Other _____                                    |

**RADIOLOGY**

**Report(s) and CD Images**

- CT \_\_\_\_\_
- MRI \_\_\_\_\_
- Ultrasound \_\_\_\_\_
- X-Ray \_\_\_\_\_
- Mammography \_\_\_\_\_
- Nuclear Medicine \_\_\_\_\_

**Reports and CD of images from study**

\_\_\_\_\_  
Name of Requestor Signature of Requestor Date of Request

\_\_\_\_\_  
Relationship to the patient Witness Name/Signature Date of Request

Signature verified by: Advocate Medical Group Employee: \_\_\_\_\_

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.