Advocate Medical Group

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:

☐Face Sheet	☐EEG/EMG
☐ER Records	☐Operative Report
☐Discharge Summary	☐Pathology Report
☐History and Physical	☐Progress Notes - Physicians
☐Consultation	☐ Progress Notes – Nurses
☐Laboratory	☐Discharge Summary - Counselor
☐HIV test results	☐Nurses' Assessment - History
☐EKG, Echo, Holter, Stress Test	☐Physical, Occupational, Speech Therapy Records
☐ Audiology report	☐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: _____