Angela Intili, M.D., Ltd.

Authorization for Release of Medical Information

I, _____, _____/_____/_____, _____
(Name of patient) (Date of birth) (Phone number)

_____ **authorize**
(Street Address) (City) (State) (Zip)

My records to be released from: _____
(Name)

_____
(Street Address) (City) (State) (Zip)

My records to be sent to: _____
(Name)

_____
(Street Address) (City) (State) (Zip)

The type of information to be disclosed (check all that apply):

(check)	Visit Date	(check)	Visit Date	Initials
_____All Records	_____	_____ Medication Records	_____	_____
_____Progress Notes	_____	_____X-ray, CT, MRI (reports only)	_____	_____
_____Discharge Summary	_____	_____Lab Reports	_____	_____
_____History and Physical	_____	_____Pathology Report	_____	_____
_____Consultation Report	_____	_____Mental Health	_____	_____
_____Operative Report	_____	_____Alcohol/Drug Report	_____	_____
_____Procedure: _____		Sexually Trans Disease	_____	_____

_____Other: _____

_____HIV (AIDS) reports _____
(Requires your signature here)

The purpose of the disclosure is: (check one)

____ Medical Care ____Payment of Claim/Benefits ____Personal Use
____ Legal Investigation ____Insurance Application ____ Other (please specify)_____

Permission to Release Records

I understand that I may revoke this authorization by written notification at any time following this date, except for the information which may have been released prior to the revocation. Unless otherwise specified, this consent will expire one year from the signed date. This authorization will be effective for medical records generated to the date of the signature.

I understand that in accordance with State and Federal confidentiality regulations the information disclosed may include reference to or treatment of alcohol/drug abuse, emotional illness, developmental disability, or psychiatric care only if I indicated above with my initials or signature. Further disclosure of this information without written consent is prohibited by law.

*** **I understand that there will be a fee charged to me to cover the cost of copying and sending my records and the medical records will take 1 week to process.*****

One year from date this form is signed

Expiration date or condition to expire: Other:_____

_____ _____
(Signature of person giving consent) (Date signed) (Witness) (Date signed)

The signature is of the _____ Patient _____ Parent of Minor _____ Legal Guardian
_____ Patient's Executor or Next of Kin
_____ Person authorized by Patient _____
(Specify relationship or authority to act)

Angela Intili, M.D., 1415 Essington Rd, Joliet, IL 60435 Phone: 815-729-2084 Fax: 815-729-2304