Community ENT & Allergy
Dr. Brian Hawkins Dr. Joseph Creely
4950 Norton Healthcare Blvd.
Suite 209
Louisville, KY 40241
Phone# 502-425-5556
Fax# 502-425-5655

Authorization to Release Healthcare Information

Patient Name: _____ Date of Birth: _____

Previous Name: _____ SS#: _____

I request & authorize _____ to release healthcare information of the above patient to:

Community ENT & Allergy
4950 Norton Healthcare Blvd.
Suite 209
Louisville, KY 40241

This request and authorization applies to:

- o Healthcare information relating to the following treatment, condition or dates:
  _____
- o All Healthcare information
- o Other:
  _____
  _____

Definition: Sexually transmitted disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simples, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethrieis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV, AIDS, and gonorrhea.

- o Yes
- o No

I authorize the release of my STD results, HIV / AIDS testing, whether negative or positive, to the person (s) listed above. I understand that the person (s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

- o Yes
- o No

I authorize the release of any records regarding drug, alcohol or mental health treatment to the person (s) listed above.

Patient signature: _____ Date: _____

Parent / Guardian signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED