C O M M U N I T Y
Ear, Nose, Throat, and Allergy
CENTA
4950 Norton Healthcare Blvd, Suite 209
Louisville, KY 40241
502-425-5556 ** Fax 502-425-5655

Authorization to Release Healthcare Information

Patient Name: _____Date of Birth: _____

Previous Name: _____SS#: _____

I request and authorize **Community ENT & Allergy** to release healthcare information to the following: **(Please provide complete name & address where records are to be sent to, if you wish to have records faxed please provide that information as well.)**

_____

_____

_____

Fax #_____

This request and authorization applies to:

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

Patient Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED