



COMMUNITY ENT

EAR, NOSE, THROAT AND ALLERGY

4950 Norton Healthcare Blvd, Suite 209
Louisville, KY 40241
Phone 502-425-5556 Fax 502-890-9870



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