Cutting Edge Testing (C.E.T) & Peter Miao M.D.

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HEALTHCARE INFORMATION AUTHORIZATION FORM

Legal Name: _____

Date of Birth: _____/_____/_____ M/F: _____

Phone Number:_____

Email: _____

Home Address: _____

City: _____ State: _____ Zip code: _____

***Preference method of contact if needed (check one):** Text [ ] Phone Call [ ] Email [ ]

I hereby authorize Cutting Edge Testing (C.E.T) and Peter Miao M.D. to release my medical records, Laboratory test results & healthcare information to the following:

(1) Name: _____

Email: _____ Phone Number: _____

(2) Name: _____

Email: _____ Phone Number: _____

*Initial: _____ This authorization will remain in effect unless changed otherwise by my written request.

PLEASE NOTE: State Law requires Cutting Edge Testing to notify the Los Angeles County Department of Health Services if you test positive for any sexually transmitted infection.

Patient Signature: _____ Date: _____

Signature of witnessed by: _____ Date: _____

Print Witness Name: _____