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

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HEALTHCARE INFORMATION AUTHORIZATION FORM

(Please fill out completely & clearly to ensure accuracy)

Legal Name: ___________________________________ Performer Name: ___________________________________

Date of Birth: ________/__________/__________ M/F______ Cell #:_____________________________________

Email:____

Current Address: ____

City: ____ State: ____________ Zip code: _________________

***Preference method of contact if needed (Other than results):** Text [ ] Phone Call [ ] Email [ ]

***Would you like to be a member of PASS database?** (Check One) Yes [ ] or No [ ]

PASS is a secondary check ONLY for Adult Industry Professionals to confirm if you are CLEARED for work.

(If you DO NOT check YES, you WILL NOT be added to the PASS System)

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:
PLEASE MAKE SURE TO FILL THIS PART OUT IF A 3rd Party NEEDS TO KNOW YOUR RESULTS.

(1) Agent/Production Name: ____
Email: ___________________________________ Phone Number: _______________________

(2) Agent/Production 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: ____