Hai T Cao MD PC - 501 5th Avenue, Brooklyn, NY 11215 Phone: (718) 576.2450 Fax: (347) 599-2298

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____ City, State, Zip _____

Social Security #: _____ Telephone #: _____

I request and authorize _____

to release healthcare information of the patient named above to:

Name: South Slope Pediatrics | Hai T Cao, MD, PC

Address: 501 5th avenue Brooklyn NY

City: Brooklyn State: NY Zip Code: 11215

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ 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.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient/Representative Signature: _____ Date Signed: _____

Relationship to Patient _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.