

Aldo F. Berti, M.D., P.A.
Miami Neurosurgery Center

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security #: _____

I request and authorize _____ to release health care information of the above named patient to:

Aldo F. Berti, MD, PA
Miami Neurosurgical Center
7600 SW 57th Avenue, Suite 304
South Miami, FL 33143

This request and authorization applies to:

___ Health care 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 simples, human papilloma virus, wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, Lymphogranuloma venereum, 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 person(s) listed above will be notified that I must give specific written permission before disclosure of these test results anyone.

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

Patient Signature: _____ Date Signed: _____