AUTHORIZATION TO RECEIVE OR RELEASE MEDICAL INFORMATION

This authorization to receive or release medical information is being requested to you, to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56 et seq. of the California Civil Code.

I hereby authorize

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To furnish to ***Gary A. Belaga, M.D. Neurologist***
2001 Union Street Suite # 104 San Francisco Ca. 94123.
Our **Fax (415)641-1932 Ph (415)641-6223**
medical records and information pertaining to medical history, mental or physical conditions, services rendered or treatment to

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Patient Name

_________________________ _________________________
Date of birth **Social Security number**

This authorization is limited to the medical records, diagnostic test results and lab results only. This information supplied is to be used for the purpose of continuing medical care. This authorization shall become effective immediately.

I understand that the requester may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically require permitted by law.

I understand that I have a right to receive a copy of this authorization upon my request.

___________________________________ **Date:** ___________________
Patient, Parent, or Guardian **Witness**___________________
Legal Representative of Patient