

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

To furnish to ***Gary A. Belaga, M.D. Neurologist***
1814-A Tice Valley Boulevard Walnut Creek, CA 94595
Phone: (925) 239-7141 Fax: (888) 838-1981

medical records and information pertaining to medical history,
mental or physical conditions, services rendered or treatment to

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.

Patient, Parent, or Guardian
Legal Representative of Patient

Date: _____
Witness _____