San Mateo Memory Center
411 Main St. Half Moon Bay, California 94019
Website: www.drmichaeldebellis.com
Main phone #: (510) 316-4364
Fax #: (877) 879-7892

Authorization for the Release of Patient Health Information

I _____ _____
(Print Full Name) (Date of Birth)

Hereby authorize:	**To disclose to:**
_____	_____
Name of Disclosing Party	Name of Recipient/Clinic
_____	_____
Address	Address
_____	_____
City State Zip	City State Zip
_____	_____
Phone Fax	Phone Fax

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here: ___
Revocation: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
Specify Records: Check the box and specify which type of information is to be disclosed.

O Neuropsychological report
O Raw Data (only released to a qualified professional)
O Other Records, _____

The recipient may use health information authorized on this form for the following purposes.

A copy of this authorization is as valid as the original. Patient has a right to a copy of this authorization.

_____ _____

Date Signature (if signed by other, please indicate relationship)