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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date of Birth: _____

Medical Record Number: _____

Name of Clinician:

I request and authorize to release healthcare information of the patient named above to the Kaiser Center located: (please circle)

Kaiser Downey 9333 Imperial Hwy Downey, CA 90242

Kaiser Lomita
 2081 Palos Verdes Dr. N Lomita, CA 90717

Kaiser Bellflower 9400 Rosecrans Ave Bellflower 90706

Kaiser South Bay
 25825 S. Vermont Ave Harbor City, CA 90710

Kaiser Baldwin Park 1011 Baldwin Park Blvd. Baldwin Park 91706

Kaiser Long Beach
 3900 E PCH Long Beach, CA 90804
 310-325-6542

This request and authorization apply to coordination of care/treatment & coordination/allocation of benefits

I understand I may revoke this authorization in writing submitted at any time to the clinician. If this authorization is not revoked it will stay in effect until termination of my enrollment in the health plan.

Client Signature: _____ Date signed: _____

Authorized Person
 (if under 18): _____ Date signed: _____

Printed Name: _____

Relationship to
 Client: _____

This disclosure is intended for the above named person(s); any further disclosure to those not named above is violation of Federal HIPPA laws.