Abbeyfield

Patty Berry, LCSW
Rosa Maria Kolts, MFT
Sue McWayne, LCSW
Talese Fernbach, MASEP
Jill Gravois, LCSW
Tamineca Lollis, LCSW
Hillary Marshall, LCSW
Evangelina Reina, LCSW

Deborah Jaffe, LCSW
Julia Cassidy, MS, RDN, CEDRD
Kimberely Beeli, LCSW
Kim Poehler, LMFT
Michael Silverman, LCSW
Ngina Tobias, LCSW
Ektha Aggarwal, LCSW
Lisa Heemer, LCSW

5479 E. Abbeyfield Street Suite 3 | Long Beach, CA 90815
Phone: 562-498-5900 | Fax: 562-498-5909 | abbeyfieldpm@gmail.com |

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Medical Record Number:_____ Abbeyfield 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 Bellflower 9400 Rosecrans Ave Bellflower 90706

Kaiser Baldwin Park 1011 Baldwin Park Bl Baldwin Park 91706

Kaiser Lomita
2081 Palos Verdes Dr N Lomita, CA 90717

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

This request and authorization applies 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.