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

Kimberely Beeli, LCSW
Michael Silverman, LCSW
Lisa Heemer, LCSW
Geraldine Tinson, LCSW
Richard Gottschalk, LMFT
Julie Clemens, LCSW
Stacey Cohn, 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: _____

Abbeyfield Clinician's Name:

_____

I request and authorize [Authorized individual] to release healthcare information of the patient named above to / from:

_____

Address: _____

_____

_____

Phone: _____

This request and authorization applies to:

☐ Coordination of care/treatment: I authorize the release of clinical information and records obtained in the course of my diagnosis/treatment.

☐ Coordination/Allocation of benefits

☐ Other:

_____

_____

_____

Client Signature: _____ Date signed: _____

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

Printed Name: _____

Relationship to Client: _____

This authorization will expire on _____or if rescinded in writing by the above.

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