NORTH LOS ANGELES COUNTY
REGIONAL CENTER

15400 Sherman Way, Suite 170 – Van Nuys, CA 91406-4211
Main: (818) 778-1900 Fax: (818) 756-6357

IMPORTANT INFORMATION

A release form needs to be completed for the following if applicable

Pediatrician
Developmental Pediatrician
Primary Care Physician
Neurologist
Orthopedic
Vocational/Rehabilitation Records
Psychiatric/Psychological
School/College and Psychological Services

USE ONE FORM FOR EACH PROVIDER LISTED ABOVE

- ✓ ***The provider address must be completed including the zip code.***
- ✓ ***Print clearly***
- ✓ ***Check the appropriate box & initial***
- ✓ ***DO NOT FORGET TO SIGN, DATE, & PRINT YOUR NAME***

INCOMPLETE FORMS WILL DELAY THE PROCESS

AN EXAMPLE SHEET IS INCLUDED

USE ONE FORM FOR EACH PROVIDER, SCHOOL, OR ENTITY.

NORTH LOS ANGELES COUNTY REGIONAL CENTER
15400 Sherman Way, Suite 170, Van Nuys, CA 91406, Telephone: (818) 778-1900; Fax: (818) 756-6357

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEDICAL AND/OR OTHER INFORMATION

TO:		...NTION: RECORDS

PLEASE PROVIDE THE NAME OF YOUR DOCTOR, SCHOOL, ETC. AND THEIR COMPLETE ADDRESS PLEASE PRINT CLEARLY

I hereby authorize the above named school, medical practitioner, hospital, clinic, mental health facility, and/or designated employees to release school or medical information as indicated below.

Please release medical records and/or other information regarding:

NAME:		DOB:	

Please Print Clearly who we are requesting records for, including their DOB

TO: NORTH LOS ANGELES COUNTY REGIONAL CENTER (NLACRC) AT...

DURATION
This authorization shall become effective immediately and shall remain in effect until__________(*enter date*) or for one year from the date of signature if no date is entered.

REVOCATION
This authorization may be revoked by the undersigned at any time. The revocation must be in writing, signed by the undersigned, and delivered to NLACRC at the address above. Written revocation will be effective upon receipt, but will not be effective to t... acted in relianc...

PLEASE CHECK THE APPROPRIATE BOX & INITIAL

REDISCLOS...
NLACRC may not re-disclose the information obtained under this authorization unless additional authorization is obtained or disclosure is specifically required or permitted by law.

SPECIFY RECORDS
Check the box and initial the type of information to disclosed:

☐ Medical information: Last 24 months of actual office visits, physical examinations, developmental assessments, hospital admission and discharge summaries. _________________ (*initial and date*)
☐ Birth Records _________________(*initial and date*)
☐ Psychiatric/ psychological information: Evaluations, medication and treatment records, hospital admission and discharge summaries, and diagnostic impressions including testing score sheets. _______________(*initial and date*)
☐ School/College and Psychological Services: AB3632 assessment, case studies, psychological, hearing, speech and language evaluations, most recent IEP transcript and/or cumulative records_________________,(*initial and date*)
☐ Vocational/Rehabilitation records___________,(*initial and date*)
☐ Other (specify)____________________________
____________________________________ (*initial and date*)

I request that the health information released pursuant to this authorization be used for the following purposes only: These records will be used by the NLACRC to evaluate and make decisions regarding eligibility and appropriate services for this individual.

I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility fo... signing this authorization. I have a right to receive a copy of this authorization for my records... an original.

DO NOT FORGET TO SIGN, DATE & PRINT YOUR NAME

____
Signature of Consumer or Consumer's Legal Representative

____
Date

____
Printed Name

____
Relationship, if signed by someone other that the consumer

Attention medical records and/or other departments: NLAC... ...e State of California's Department of Developmental Services. There is no funding provision in our contract wit... ...ds. We do hope, however, that you will be able to assist us in providing this information. Form Revised 07/18/...

INCOMPLETE FORMS WILL DELAY THE PROCESS

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INFORMACION IMPORTANTE

Una forma de liberación de información necesita ser completada para cada uno de los siguientes proveedores de servicio si es aplicable:

Pediatra
Especialista del desarroyo mental
Médico de cuidado primario
Neurologo
Ortopedico
Registros de Rehabilitacion Profesional
Cuidado Siquiatrico y Sicologico
Servicios Sicologicos de Escuela/Colegio

USE UNA FORMA POR CADA UNO DE LOS PROVEEDORES DE SERVICIO LISTADOS ANTERIORMENTE.

Por favor siga las instrucciones:

- Poner la dirección completa del proveedore de servicio incluyendo zona postal
- Escribir claramente
- Marcar la casilla apropiada e inicialarla
- NO OLVIDE FIRMAR LA FORMA, PORNER LA FECHA Y PONER SU NOMBRE

FORMAS INCOMPLETAS SON CAUSA DE RETRASO EN EL PROCESO

UN EJEMPLO DE LA FORMA ESTA INCLUIDA EN ESTE PAQUETE

NORTH LOS AN[...]**ER**
15400 Sherman Way, Su[...]**0; Fax: (818) 756-6357**

> **USE UNA FORMA PARA CADA PROVEEDOR, ESCUELA O ENTIDAD.**

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEDICAL AND/OR OTHER INFORMATION

TO:		ATTENTION: RECORDS

> **POR FAVOR PROPORCIONE EL NOMBRE Y LA DIRECCION DE SU DOCTOR, ESCUELA, ETC. POR FAVOR ESCRIBA CLARO**

I hereby authorize the above named [...]**, clinic, mental health facility, and/or designated employees to release school or medical information as indicated below.**

Please release medical records and/or other information regarding:

NAME:		DOB:	

> **Por favor proporcione el nombre de quien se solicita La informacion y fecha de nacimiento**

TO: NORTH LOS ANGELES COUNTY REGIONAL CENTER (NLACRC) A

DURATION
This authorization shall become effective immediately and shall remain in effect until__________(*enter date*) or for one year from the date of signature if no date is entered.

REVOCATION
This authorization may be revoked by the undersigned at any time. The revocation must be in writing, signed by the undersigned, and delivered to NLACRC at the address above. Written revocation will be effective upon receipt, but will not be effective to t[...] acted in relianc[...]

> **POR FAVOR MARQUE LA CASILLA APROPIADA E INICIALE**

REDISCLOS[...]
NLACRC may not [...] under this authorization unless additional authorization is obtained or disclosure is specifically required or permitted by law.

SPECIFY RECORDS
Check the box and initial the type of information to disclosed:

☐ Medical information: Last 24 months of actual office visits, physical examinations, developmental assessments, hospital admission and discharge summaries. ________________ (*initial and date*)
☐ Birth Records ________________(*initial and date*)
☐ Psychiatric/ psychological information: Evaluations, medication and treatment records, hospital admission and discharge summaries, and diagnostic impressions including testing score sheets. _______________*(initial and date)*
☐ School/College and Psychological Services: AB3632 assessment, case studies, psychological, hearing, speech and language evaluations, most recent IEP transcript and/or cumulative records_________________,(*initial and date*)
☐ Vocational/Rehabilitation records____________,(*initial and date*)
☐ Other (specify)____________________________________
____ (*initial and date)*

I request that the health information released pursuant to this authorization be used for the following purposes only: These records will be used by the NLACRC to evaluate and make decisions regarding eligibility and appropriate services for this individual.

I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility fo[...] signing this authorization. I have a right to receive a copy of this authorization for my records[...] an original.

> **NO OLVIDE FIRMAR, PONER LA FECHA Y PONER SU NOMBRE**

______________________________________ ____________________________
Signature of Consumer or Consumer's Legal Representative Date

______________________________________ ____________________________
Printed Name [...]at the consumer

> **FORMAS INCOMPLETAS RETRASARAN EL PROCESSO**

Attention medical records and/or other departments: NLACRC is a non-profit social [...]partment of Developmental Services. There is no funding provision in our contract with the State of California to [...]that you will be able to assist us in providing this information. Form Revised 07/18/06