



**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**

<b>TO:</b>		<b>ATTENTION: RECORDS</b>

**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:

<b>NAME:</b>		<b>DOB:</b>	
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**TO: NORTH LOS ANGELES COUNTY REGIONAL CENTER (NLACRC) ATTENTION: INTAKE DEPT.**

**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.

**REVOCAION**

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 the extent that the requester or others have acted in reliance upon this authorization.

**REDISCLASURE**

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 for benefits may not be conditioned on signing this authorization. I have a right to receive a copy of this authorization for my records. A copy of this authorization is valid as an original.

\_\_\_\_\_  
Signature of Consumer or Consumer's Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship, if signed by someone other than the consumer

Attention medical records and/or other departments: NLACRC is a non-profit social service agency funded by the State of California's Department of Developmental Services. There is no funding provision in our contract with the State of California to pay for the requested records. We do hope, however, that you will be able to assist us in providing this information. Form Revised 07/18/06