



North Los Angeles County Regional Center

~~SECRET~~
~~DISSEMINATION~~
~~RESTRICTED~~

Consent for Intake and Assessment Services

By signing this form, I hereby consent to the assessment of the individual named on this form for the purpose of determining eligibility for Regional Center services as per the Lanterman Developmental Disability Services Act. I understand that assessment may include collection and review of available historical diagnostic information, provision or procurement of necessary tests and evaluations and summarization of developmental levels and service needs. I understand that the North Los Angeles County Regional Center may consider evaluations and tests, including, but not limited to, intelligence tests, adaptive functioning tests, neurological and neuropsychological tests, diagnostic tests performed by a physician, psychiatric tests, and other tests and evaluations that have been performed by, and are available from, other sources. (California Welfare and Institutions code Section 4642, 4653)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that all information and records obtained by the North Los Angeles County Regional Center in the course of providing intake and assessment services are confidential.

Please review the enclosed **Notice of Privacy Practices**. By signing this form, I acknowledge that I was provided a copy of the *Notice of Privacy Practices* of the North Los Angeles County Regional Center. I acknowledge that I have read (or had the opportunity to read) and understood the Notice. I understand that I can request a paper copy of the Notice at any time.

Applicant Name

Signature

Date

If Applicant is a minor or unable to sign:

Name of Parent or Authorized Representative

Signature

Date

Relationship to Applicant



North Los Angeles County Regional Center

9200 Oakdale Avenue, Suite 100, Chatsworth, CA 91311 - (818) 778-1900
25360 Magic Mountain Parkway, Suite 150, Santa Clarita, CA 91355 - (661) 775-8450
43850 10th Street West, Lancaster, CA 93534 - (661) 945-6761

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

To: Attention:

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: Birth Date:

Release medical information to: NORTH LOS ANGELES COUNTY REGIONAL CENTER (NLACRC)

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.

REVOCAATION

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 disclose:

- Medical Information:** Birth Records, Office visits, physical examinations, developmental assessments, hospital admission and discharge summaries.
- Psychiatric/Psychological Information:** Evaluations, medication and treatment records, hospital admission and discharge summaries, and diagnostic impressions including testing score sheets.
- School/College and Psychological Services or Vocational/Rehabilitation records:** AB3632 assessment, case studies, psychological, hearing, speech and language evaluations, most recent IEP transcript and/or cumulative records.
- HIV, AIDS, Substance Abuse Treatment.**
- Other (specify)**

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 consumer

Please complete and fax entire form to Intake Department (818) 756-6357 or submit electronically to intake@nlacrc.org



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Please keep for your records.



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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The North Los Angeles County Regional Center (NLACRC) is mandated by law to maintain the privacy of your Protected Health Information (PHI). PHI is information that identifies you in any form (electronic, written, oral, etc.) collected, created, maintained, or received by NLACRC relating to your past, present or future physical/ mental health or condition. We are required by law to provide you, a NLACRC consumer, with this "Notice of Privacy Practices" explaining our legal duties and privacy practices concerning your PHI. We are also required to abide by the terms of the current version of this Notice. In this Notice, the terms "NLACRC", "we", "us", and "our" refer to the North Los Angeles County Regional Center.

WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU WITHOUT YOUR WRITTEN PERMISSION IN THE FOLLOWING SITUATIONS:

Treatment: We may use and disclose your PHI for the provision, coordination and/or management of health care and related services. For example, we may disclose your PHI to case managers, doctors, health care providers, vendors, business associates, caregivers, family and other persons who are involved in taking care of you, both within and outside of NLACRC.

Health Care Operations: We may use and disclose your PHI for our Operations. For example, activities involving, but not limited to, case management, quality assessment and improvement, risk mitigation, oversight by state and federal agencies, audit, training, and advocacy.

Payment: We may use your PHI to, for example, determine our responsibility to pay for, or to permit us to bill and collect payment for the treatment and health-related services that you receive.

Appointment Reminders and Notification: We may contact you about appointments or provide you with information that may be of your interest.

Public Health Activities: We may share your PHI for Public Health Activities, for example, when related to prevention of disease, injury or disability; for tracking and monitoring of certain medical products.

Judicial Proceedings: We may use or disclose your PHI for Judicial Proceedings, for example, as part of an administrative hearing, in response to an order of a court, or a subpoena.

Law Enforcement: We may share your PHI with Law Enforcement Agencies, for example, to respond to a search warrant or to report a crime.

Research: We may use or share your PHI for research approved by the NLACRC Institutional Review Board, a committee that is responsible, under law, to protect the safety of the participants and the confidentiality of PHI. Such research may also require your specific authorization.

Serious Threat to Health or Safety or Disaster Relief: We may use or share your PHI to prevent serious/ imminent threat to your or another person's health and safety.

National Security: We may share PHI with authorized federal officials for intelligence, and other national security activities authorized by Law.

Coroners, Medical Examiners, Funeral Directors and Organ Donation: We may share your PHI with these agencies, as applicable by law, to allow these individuals to perform their official duties; for example, to identify a deceased person.

Correctional Institutions: If you are under law enforcement custody, we may share your PHI with correctional institutions or law enforcement, as needed, for your health care.

As Mandated by Law: We will share your PHI when otherwise required by law.

OTHER USES OF PROTECTED HEALTH INFORMATION

Other uses and disclosures of Protected Health Information not covered by this notice or the laws that apply to us will be made only with your written permission. The permission you provide us to use or disclose your PHI may be revoked in writing at any time. If you revoke your permission, this will stop any further use or disclosure of your PHI for the purposes covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.



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There are stricter requirements for the use and disclosure of certain types of PHI, for example, records about HIV/AIDS, mental health, drug and alcohol treatment. This type of information can only be released in accordance with those stricter laws.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION INCLUDE:

Right to Inspect and Copy your Records

You have the right to request in writing to inspect and copy your PHI in designated record sets. If we deny a request, we will do so in writing giving our reasons and you have the right to have that decision reviewed.

Right to Request Amendments to your Records

If you feel that your PHI is incorrect or incomplete, you have the right to ask in writing that we amend it, stating why we should make the correction or addition. If we deny your request, we will do so in writing giving our reasons, and you may file a written statement of disagreement.

Right to Request Restrictions

You have the right to request in writing a restriction or limitation of our use or disclosure of your PHI. You may request that your PHI not be shared with others, like a family member or friend. However, by law, we do not have to agree to your request.

Right to Request Confidential Communications

You have the right to request in writing that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. When we can reasonably or lawfully agree to your request, we will.

Right to an Accounting of Disclosures

You have the right to request in writing an accounting of our disclosures of your PHI for up to 6 years before your request, but not for disclosures made before April 14, 2003. An accounting does not include disclosures to carry out Treatment, Health Care Operations, Payment, General Notification, Law Enforcement, National Security, and to Correctional Institutions as well as otherwise Mandated by Law. Additionally, an accounting does not include disclosures for which NLACRC had a signed authorization, disclosures to you, your care giver, or persons acting on your behalf.

Right to a Paper Copy of this Notice

You have the right to receive a paper copy of this Notice upon request at any time by contacting the HIPAA Coordinator at NLACRC

CHANGES TO THIS NOTICE

We reserve the right to change this Notice and our privacy practices at any time, as long as the change is consistent with state and federal law. Any revised Notice will apply both to the PHI we already have about you at the time of the change, and any PHI created or received after the change takes effect. A copy of the current Notice will be posted all NLACRC offices in a clear and prominent location. If we change our Notice, you may obtain a copy of the revised Notice by contacting the HIPAA Coordinator at NLACRC.

QUESTIONS/COMPLAINTS

If you have questions regarding this Notice or our privacy practices, or if you are writing about your PHI, including requests for restrictions on its use or disclosure, or to make a complaint about our privacy practices, please write to the HIPAA Coordinator at NLACRC, 9200 Oakdale Avenue, Suite 100, Chatsworth, CA 91311, or call 818-778-1900. If you believe your privacy rights have been violated, you may also notify the Secretary of the Department of Health and Human Services (HHS). You will not be penalized for filing a complaint.

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

(Check One)

- Already registered. I am registered to vote at my current residence address.
- Yes. I would like to register to vote. (Please fill out the attached voter registration form.)
- No. I do not want to register to vote.

NOTE: IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME. YOU MAY TAKE THE ATTACHED VOTER REGISTRATION FORM TO REGISTER AT YOUR CONVENIENCE.

Applicant Name _____

Date _____

Important Notices

1. Applying to register or declining to register to vote will **not** affect the amount of assistance that you will be provided by this agency.
2. If you would like help in filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.
3. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party preference or other political preference, you may file a complaint with the Secretary of State by calling toll-free (800) 345-VOTE (8683) or you may write to: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. For more information on elections and voting, please visit the Secretary of State's website at www.sos.ca.gov.