EASTERN LOS ANGELES REGIONAL CENTER

1000 S. Fremont Ave. • P.O. Box 7916 • Alhambra, CA 91802-7916 • (626) 299-4700 • FAX (626) 281-1163

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF CONFIDENTIAL MEDICAL OR HEALTH RELATED INFORMATION

To: _____

_____

_____

Attn: MEDICAL RECORDS/SCHOOL RECORDS/CONSUMER RECORDS

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

Please release medical records and related information regarding:
Name: _____ Date of Birth: _____ SS# _____

☐ Release medical information to: EASTERN LOS ANGELES REGIONAL CENTER (ELARC)
Attention: _____

☐ I hereby authorize The Eastern Los Angeles Regional Center to release Medical Records and Related information indicated below to: _____

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 ELARC 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

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REDISCLOSURE
I understand that the requester may not lawfully further use or disclose the health information unless authorization is obtained from me or unless disclosure is specifically required or permitted by law.

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

☐ Medical information: Last 12 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, and discharge summaries, and diagnostic Impressions including testing score sheets._____ *(Initial and date)*
☐ Psycho Educational Information *(Initial and Date)*
☐ Individual Education Plan *(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 ELARC to evaluate and make decisions regarding eligibility and appropriate services for this individual.

NOTE: Your protected health information can be disclosed only if this authorization form is completely filled out and is dated and signed. See, Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 C.F.R.§ 164.508(b)(2)(ii), 164.501; Cal. Civil Code §§ 56.11, 56.05(j)

A copy of this authorization is valid as an original. I have a right to receive a copy of this authorization for my records.
Client signature (if over 18 years of age) _____ ***Date:*** _____

Parent/Legal Guardian _____ ***Date:*** _____
Witness _____ ***Date:*** _____