NORTH LOS ANGELES COUNTY REGIONAL CENTER
15400 Sherman Way, Suite 170, Van Nuys, CA 91406, Telephone: (818) 778-1900; Fax: (818) 756-6140

AUTHORIZATION FOR RELEASE OF MEDICAL AND/ OR PSYCHOLOGICAL INFORMATION

I hereby authorize the **NORTH LOS ANGELES COUNTY REGIONAL CENTER (NLACRC)** and/or its designated employees to release medical and/or psychological information as indicated below.

Please release medical and/or psychological records and information regarding:

Name:______________________________ Date of birth:______________________
UCI#______________________________

Release records to: ______________________________ Attention: ______________________
____
____
____

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

REDISCLOSURE
NLACRC and many other organizations and individuals are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may not longer be protected by state or federal confidentiality laws.

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.

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

- ☐ Medical information. ____________ *(initial and date)*
- ☐ Psychiatric/ psychological information.
  ____________*(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:
____
____
____

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 that the consumer

Revised 4-5-05