



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900

28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450

43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (661) 945-6761

Intake Application (For Children Over 3 Years of Age and Adults)

This application is to assist the North Los Angeles County Regional Center (NLACRC) to determine eligibility for services under the Lanterman Developmental Disabilities Services Act. To be eligible for Regional Center Services an individual must have a Developmental Disability as per California Law and Regulation. A developmental disability is a condition attributable to:

- (1) Mental Retardation
- (2) Epilepsy
- (3) Cerebral Palsy
- (4) Autism
- (5) Disabling conditions found to be closely related to mental retardation or requiring treatment similar to.

Additionally, the disability must: Originate prior to the age of 18, continues or is expected to continue indefinitely and constitutes a substantially for the person. Substantially disability means significant functional limitation in three or more of the following areas of life activity: self care, receptive and expressive language, learning, mobility, self direction, capacity of independent living, economic self sufficiency. A developmental disability does not include other handicapping conditions that are solely physical in nature, solely psychiatric in nature and solely learning disabilities.

In order to determine the applicant's eligibility, NLACRC will complete an intake assessment which may include collection of historical diagnostic information, such as medical records, school records, prior psychological testing as well as provision of diagnostic evaluation (s) if indicated. This application contains the necessary forms required for NLACRC to initiate the evaluation process. The evaluation process cannot begin prior to receipt of your written consent. The applicant's information is confidential and will not be released without your written consent. Eligibility determination may take up to 120 days. To begin the process:

1. Is a developmental disability suspected? If a developmental disability as described above is not suspected, Regional Center may not be the appropriate agency to meet the applicant's needs and an application should NOT be completed.
2. Do you live in the NLACRC catchment area? **NLACRC serves individuals who reside in the San Fernando, Santa Clarita, or Antelope Valleys of Los Angeles County ONLY.** If you do not live in one of these areas, you need to apply for services at the Regional Center that serves the area in which you live, please visit <http://www.dds.ca.gov/RC/RCzipLookup.cfm> to find the Regional Center that serves your Zip code.
3. Please complete the application as accurately and completely as possible. **The collection of the demographic information on this application is required by the State of California, Department of Developmental Services.**
4. Please **sign** the consent for evaluation and services on page 8. **The evaluation process cannot begin prior to receipt of your written consent.**
5. Please **sign** medical, psychological, school record releases on pages 9 - 14. These releases allow us to obtain medical records, psychological and educational information are a critical part of the eligibility determination process.
6. **FAX the entire application with signature pages (Pages 1-14) to NLACRC intake department 818 756 6357.**
7. **You may also submit the application by email instead of fax by pressing the submit button at the top of this application or by sending to intake@nlarc.org. If you are submitting by email, make sure all the signature lines are signed and dated. You may use a digital signature.**
8. Please read the Notice of Privacy practice (pages 15 and 16) and keep for your records. **DO NOT FAX** back to NLACRC. These pages contain information about the privacy of your health information.
9. You will receive confirmation of that your application has been received within 3 business days.

Thank you for your interest in the North Los Angeles County Regional Center. Please visit our website www.nlarcc.org. You can find more information about Regional Centers at www.dds.ca.gov



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900
28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450
43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (661) 945-6761

Intake Application

For Children Over 3 Years of Age and Adults

Applicant's Information:

First Name	Middle Name	Last Name
Birth Date	Age	Birth Place
<input type="checkbox"/> Male <input type="checkbox"/> Female		
Gender	Primary Language	Ethnicity
Social Security Number	Marital Status	
If the Applicant's name has been changed, please list previous name below.		
Previous First Name	Previous Middle Name	Previous Last Name
Who does the applicant live with? <input type="radio"/> Parent/s <input type="radio"/> Foster Parent/s <input type="radio"/> Facility <input type="radio"/> Independent		
Street		
City	State	Zip
Primary Phone Number	Alternate Phone Number	Email Address
Who is the primary responsible party that can be contacted regarding this application?		
First Name	Last Name	Relationship
Primary Phone Number	Alternate Phone Number	Email Address
Please provide information regarding the individual, agency, or office that made referral.		
Name of Agency / Contact Person	Primary Phone Number	Fax / Email

Has the applicant previously received assessment or services from North Los Angeles County Regional Center or another Regional Center? Yes No

If "Yes," please name the Regional Center in the box.

Is the applicant under a court appointed conservatorship? Yes No



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900
28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450
43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (661) 945-6761

Father's Information

Does the Father live with the Applicant? If, "Yes" please check here.

If the Father's information is unknown please check here.

First Name	Middle Name	Last Name
Birth Date	Birth Place	Language
Street		
City	State	Zip
Phone Number	Social Security Number	
Employer's Name		Job Title
Disabled	<input type="radio"/> Yes <input type="radio"/> No	Deceased <input type="radio"/> Yes <input type="radio"/> No
Marital Status <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Single <input type="radio"/> Widower		

Mother's Information

Does the Mother live with the Applicant? If, "Yes" please check here.

If the Mother's information is unknown please check here.

First Name	Middle Name	Last Name (Maiden)
Birth Date	Birth Place	Language
Street		
City	State	Zip
Phone Number	Social Security Number	
Employer's Name		Job Title
Disabled	<input type="radio"/> Yes <input type="radio"/> No	Deceased <input type="radio"/> Yes <input type="radio"/> No
Marital Status <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Single <input type="radio"/> Widow		



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900
28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450
43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (661) 945-6761

Developmental Disability: Please provide information regarding the area of developmental disability that is suspected or diagnosed for the applicant. You may provide information for more than one area of developmental disability. If an area of developmental disability is not suspected, please leave that section blank.

Please provide the name of any health professional where indicated below and list their contact information on pages 6 and 7 so that records can be requested.

3. Cerebral Palsy:

Has the applicant been diagnosed by a health care professional with Cerebral Palsy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Professional Name:		Date of diagnosis:	
Please describe the type of cerebral palsy and how the applicant is impacted in their daily functioning.			

Does applicant use adaptive equipment? none Wheelchair Walker AFO/Brace

4. Epilepsy:

Has the applicant been diagnosed by a physician or neurologist with Epilepsy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Professional Name:		Date of diagnosis:	
If yes, what age was the applicant diagnosed with Epilepsy?			
Is applicant taking medicine for Epilepsy (Seizures)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please list the medication(s) used for Epilepsy (Seizures) below and also describe the type of seizures and how the applicant is impacted in their daily functioning.			

How frequent are the seizures? Daily Weekly 1 A Month 1 A Year None In This Past Year

5. Other:

If needed, please describe below any other concerns about the applicant that have not been addressed above.



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900
28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450
43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (661) 945-6761

Developmental Disability: Please provide information regarding the area of developmental disability that is suspected or diagnosed for the applicant. You may provide information for more than one area of developmental disability. If an area of developmental disability is not suspected, please leave that section blank.

Please provide the name of any health professional where indicted below and list their contact information on pages 6 and 7 so that records can be requested.

1. Mental Retardation

Has the applicant been diagnosed by a health care professional with Mental Retardation? Yes No

Professional Name: Date of diagnosis:

In box below please describe why mental retardation is suspected.

2. Autism

Has the applicant been diagnosed by a health care professional with Autism? Yes No

Professional Name: Date of diagnosis:

In box below please describe why Autism is suspected.



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900
28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450
43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (661) 945-6761

1. Medical History

Does the applicant have any medical diagnoses or chronic health conditions? Yes No

Please describe in the box below.

Physician name:

Please list any medications that the applicant is currently taking for their medical condition.

2. Mental Health History

Does the applicant have a current mental health (psychiatric) diagnosis? Yes No

Please describe in the box below.

Mental Health provider name:

Please list any medications that the applicant is currently taking for their mental health (psychiatric) condition.

3. School History

 Please list school name and contact information on page 6 so records can be requested.

Is the applicant currently or previously been in a special education program or had an IEP (Individual Education Plan)? Yes No

Did the applicant graduate from high school? Yes No

4. Other Services

Has the applicant received services through California Children's Services? Yes No

Has the applicant received services through the Department of Rehabilitation? Yes No

Insurance Information

Medi-Cal

Insurance Company Name

Name of Policy Holder

Insurance Policy Number



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900
28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450
43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (661) 945-6761

Clinician / Educational Contact Information For Record Request

Please indicate the name and contact information, as applicable, for the current physician, any medical specialist, psychologist or mental health provider, and last school attended and then please sign the corresponding consents to obtain current records from these providers on pages 9 - 14.

A. Current Physician.

Name		
Street		
City	State	Zip
Phone Number		

B. Other Current Physician, Medical Specialist, Hospital, Psychologist, or Mental Health Specialist.

Name		
Street		
City	State	Zip
Phone Number	Specialty	

C. Current School or last school attended.

Name		
Street		
City	State	Zip
Phone Number		



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900
28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450
43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (661) 945-6761

D. Other Current Physician, Medical Specialist, Hospital, Psychologist, Mental Health Specialist, or School.

Name		
Street		
City	State	Zip
Phone Number		

E. Other Current Physician, Medical Specialist, Hospital, Psychologist, Mental Health Specialist, or School..

Name		
Street		
City	State	Zip
Phone Number		Specialty

F. Other Current Physician, Medical Specialist, Hospital, Psychologist, Mental Health Specialist, or School.

Name		
Street		
City	State	Zip
Phone Number		Specialty



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900
28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450
43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (661) 945-6761

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.

5 dd`]WUbhBUa Y

BUa YUbX'Relationshipz]Zg][bYX'Vmigca YcbY'cH Yf`R Ub`Udd`]WUbh



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900
28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450
43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (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.

REVOCACTION

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.
_____ (initial) _____ (date)
- Psychiatric/Psychological Information:** Evaluations, medication and treatment records, hospital admission and discharge summaries, and diagnostic impressions including testing score sheets.
_____ (initial) _____ (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) _____ (date)
- Vocational/Rehabilitation records**
_____ (initial) _____ (date)
- Other (specify)**
_____ (initial) _____ (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 consumer _____

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



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900
28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450
43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (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.

REVOCACTION

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.
_____ (initial) _____ (date)
- Psychiatric/Psychological Information:** Evaluations, medication and treatment records, hospital admission and discharge summaries, and diagnostic impressions including testing score sheets.
_____ (initial) _____ (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) _____ (date)
- Vocational/Rehabilitation records**
_____ (initial) _____ (date)
- Other (specify)**
_____ (initial) _____ (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 consumer _____

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



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900
28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450
43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (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.

REVOCACTION

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.
_____ (initial) _____ (date)
- Psychiatric/Psychological Information:** Evaluations, medication and treatment records, hospital admission and discharge summaries, and diagnostic impressions including testing score sheets.
_____ (initial) _____ (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) _____ (date)
- Vocational/Rehabilitation records**
_____ (initial) _____ (date)
- Other (specify)**
_____ (initial) _____ (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 consumer _____

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



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900
28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450
43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (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.

REVOCACTION

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.
_____ (initial) _____ (date)
- Psychiatric/Psychological Information:** Evaluations, medication and treatment records, hospital admission and discharge summaries, and diagnostic impressions including testing score sheets.
_____ (initial) _____ (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) _____ (date)
- Vocational/Rehabilitation records**
_____ (initial) _____ (date)
- Other (specify)**
_____ (initial) _____ (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 consumer _____

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



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900
28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450
43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (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.

REVOCACTION

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.
_____ (initial) _____ (date)
- Psychiatric/Psychological Information:** Evaluations, medication and treatment records, hospital admission and discharge summaries, and diagnostic impressions including testing score sheets.
_____ (initial) _____ (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) _____ (date)
- Vocational/Rehabilitation records**
_____ (initial) _____ (date)
- Other (specify)**
_____ (initial) _____ (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 consumer _____

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



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900
28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450
43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (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.

REVOCACTION

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.
_____ (initial) _____ (date)
- Psychiatric/Psychological Information:** Evaluations, medication and treatment records, hospital admission and discharge summaries, and diagnostic impressions including testing score sheets.
_____ (initial) _____ (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) _____ (date)
- Vocational/Rehabilitation records**
_____ (initial) _____ (date)
- Other (specify)**
_____ (initial) _____ (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 consumer _____

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



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900

28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450

43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (661) 945-6761

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.



North Los Angeles County Regional Center

15400 Sherman Way Ste. #170 - Van Nuys, C.A. 91406 - (818) 778-1900

28470 Avenue Stanford, Ste. #100 - Santa Clarita, C.A. 91355 - (661) 775-8450

43210 Gingham Avenue, Ste. #6 - Lancaster, C.A. 93535 - (661) 945-6761

NOTICE OF PRIVACY PRACTICES

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, 15400 Sherman Way, Suite 170, Van Nuys CA 91406, 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.