INLAND REGIONAL CENTER

P. O. Box 19037, San Bernardino, CA 92423
Telephone: (909) 890-3000
Fax: (909) 890-3001

Authorization to Release Confidential/Protected Health Information

Consumer Information

______________________________ Consumer/Applicant Name (Last, First)

______________________________ AKA (Last, First), *if applicable*

______________ Date of Birth

______________ UCI Number

______________________________ Med. Record Number, *if known*

Release To

I authorize Inland Regional Center to release the records specified below to:

Person/Business: ______________________________
Address: ______________________________
City/State/Zip: ______________________________
Phone: ________________ Fax: ____________
Email: ______________________________

Purpose

For the following:
___ Application for Benefits
___ Personal Use
___ Legal
___ Other:
____
____

Information to Release

Date of Records: ______________________________
____ Eligibility Determination (ICRC 53/292)
____ IRC Psychological/Eligibility Assessment(s)
____ Individual Program Plan(s)
____ Client Developmental Evaluation Report (CDER)
____ Interdisciplinary/Title 19 Notes
____ HIV/AIDS Test Results/Treatment Records
____ Genetic Testing/Reports
____ Medical Records (Specify by provider/type below)*
____ Legal Records (Specify)*
____ Assessments/Service Plans/Progress Reports (Specify)*
____ Other/*Specify: ______________________________
____
____
____

Records identified above may include records obtained from other sources in the course of providing regional center services.

Fees

Fees may be charged for record production prior to release of records. (*WIC* § 4725 and 17 *CCR* § 52167).

Fees will not apply to record requests related to a pending fair hearing matter or by non-profit or government agencies.

Confidential Consumer Information
See California Welf. & Inst. § 4514

Complete Other Side

<table>
<tr><td>Delivery Instructions</td><td>☐ Mail/Fax/Email records directly to person or organization specified.
☐ Call Requester when records are ready for pick up.
I authorize ____________________________ to pick up requested record copies.
Relationship to consumer/applicant: ________________________
☐ Other: ____</td></tr>
<tr><td>Notice of Rights</td><td>I understand that:
1. My application for, or continued eligibility for, regional center services will not be denied on the sole basis of a refusal to sign this authorization. However, information and records, or lack thereof, may be used to assist the regional center in its evaluation for eligibility and/or needed services.
2. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
3. I have a right to receive a copy of this authorization.
4. I may revoke this authorization in writing at any time. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation.
5. The information released in response to this authorization may be re-disclosed to other parties and no longer be protected under Health Insurance Portability and Accountability Act (HIPAA). California law prohibits the person/agency receiving my information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law. (Civ. Code §§ 1798 et seq., WIC § 4514.)
See CFR § 164.508 (c)(2)(i)-(iii)</td></tr>
<tr><td>Expiration</td><td>Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire two years from the date hereof, unless otherwise specified:
____.</td></tr>
<tr><td>Signature</td><td>AUTHORIZATION IS NOT VALID IF IT IS NOT FILLED OUT COMPLETELY PRIOR TO SIGNATURE

____________________________________ ______________
Signature of Consumer/Applicant or Legally Authorized Representative — Date

____________________________________ ______________
Name of Legally Authorized Representative — Relationship</td></tr>
</table>

Confidential Consumer Information
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Complete Other Side