



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), <i>if applicable</i>	
	_____ Date of Birth UCI Number Med. Record Number, <i>if known</i>	
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: _____ ___ Early Start Records (Specify by provider/type below)* ___ 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: _____ _____ _____ <i>Records identified above may include records obtained from other sources in the course of providing regional center services.</i>	Fees
		Fees may be charged for record production prior to release of records. (<i>WIC § 4725 and 17 CCR § 52167</i>). 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

Delivery Instructions	<input type="checkbox"/> Mail/Fax/Email records directly to person or organization specified. <input type="checkbox"/> Call Requester when records are ready for pick up. I authorize _____ to pick up requested record copies. Relationship to consumer/applicant: _____ <input type="checkbox"/> Other: _____				
Notice of Rights	I understand that: <ol style="list-style-type: none"> 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. (<i>Civ. Code</i> §§ 1798 et seq., <i>WIC</i> § 4514.) <p style="text-align: right;"><i>See CFR § 164.508 (c)(2)(i)-(iii)</i></p>				
Expiration	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: _____				
Signature	AUTHORIZATION IS NOT VALID IF IT IS NOT FILLED OUT COMPLETELY PRIOR TO SIGNATURE				
	<table style="width: 100%; border: none;"> <tr> <td style="width: 70%; border: none;"> _____ Signature of Consumer/Applicant or Legally Authorized Representative </td> <td style="width: 30%; border: none;"> _____ Date </td> </tr> <tr> <td style="border: none;"> _____ Name of Legally Authorized Representative </td> <td style="border: none;"> _____ Relationship </td> </tr> </table>	_____ Signature of Consumer/Applicant or Legally Authorized Representative	_____ Date	_____ Name of Legally Authorized Representative	_____ Relationship
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