SAN GABRIEL/POMONA REGIONAL CENTER

75 Rancho Camino Drive, Pomona, CA 91766
(909) 620-7722

AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION

CLIENT NAME: _____ UCI#:_____
DOB: _____

I authorize exchange of the following information between the San Gabriel/Pomona Regional Center and
_____
_____

[ ] Birth records (including labor, delivery and nursing notes on the mother)
Mother's maiden name: _____
[ ] Medical Records, specifically:
[ ] History and Physical [ ] Admission Summary
[ ] Discharge Summary [ ] Consultation Reports
[ ] Therapy Reports [ ] CT SCAN/MRI Reports
[ ] Other: _____
[ ] Any social or psychological information on the client
[ ] School: ___ Psychological ___ IEP ___ Class Progress
_____ Name of School
[ ] Social Assessment: _____
[ ] Other: _____

In accordance with the California Welfare and Institutions Code, Section 4514(a), the consent of the person with developmental disability, or his or her guardian or conservator shall be obtained before information or records may be disclosed.

I understand the information obtained by use of this authorization (which is done at my request) will be used by SAN GABRIEL/POMONA REGIONAL CENTER to determine eligibility and for planning services for the above-named individual. This authorization is voluntary and any service provided, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization except if such authorization's purpose is to obtain information in connection with eligibility.

I also authorize SAN GABRIEL/POMONA REGIONAL CENTER to release any such information to public or private agencies conducting or planning education or other programs for the above-named individual as lawfully required or as I may authorize.
The information that has been disclosed to you are from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. 42 CFR part 2 prohibits unauthorized disclosure of these records.

I agree a copy of this form shall be as valid as the original. I have a right to receive a copy of this authorization. I acknowledge that this authorization was filled out completely when I signed the authorization. I agree this authorization shall be valid for one year from the date shown below unless I revoke this authorization in writing at any time before the expiration date.
I have received a copy of this authorization: Yes [ ] Copy Declined: [ ]

Dated this _____ day of _____, 20 _____.

_____ _____
Signature of parent/guardian/conservator Relationship to above-named person

_____
Signature of Client (if 18 years of age or older)

CONFIDENTIAL CLIENT INFORMATION
GABRIEL/POMONA VALLEYS
DEVELOPMENTAL SERVICES, INC.
See California Welfare & Institutions Code, Section 4514

cc: Client file

SGPRC 202 (01/18)