ALTA CALIFORNIA
REGIONAL CENTER

CONSENT TO EXCHANGE INFORMATION

EXPLANATION: *This Authorization is necessary for us to comply with state and federal laws pertaining to the use or disclosure of protected health information ("PHI") about the patient identified below. Please provide all requested information. Failure to provide all requested information may prevent (Hospital or facility) from acting on this Authorization.*

Name:	Date of Birth:
Other Names [a.k.a.]:	

1. PERSONS AUTHORIZED TO DISCLOSE PHI. I authorize the following person(s) or class of persons to disclose the health information about patient as described in Section 2 below:
Provider name:

2. DESCRIPTION OF INFORMATION. This Authorization permits the use and/or disclosure of the following information about patient: *(Check all applicable boxes and initial selection as required.)*

☐ All information/records
☐ Medical/Dental
☐ IPP/ IFSP
☐ Educational
☐ Vocational
☐ Other (specify):
☐ Social
☐ Psychological

I understand that the information to be released may also include any medical history, physical or mental condition, services rendered or treatment received.

3. AUTHORIZED USERS AND RECIPIENTS. I hereby authorize the following person or class of persons to receive and/or use the health information described in Section 2 above: *[State name and title (if applicable)]*.

Name:	
Address:	City/State/Zip:

4. PURPOSE. I hereby authorize the information checked in Section 2 above to be used and/or disclosed for the following purposes: *(Check all applicable boxes)*

☐ Requested by patient or personal representative.
☐ Others:

5. RIGHT OF REVOCATION. I understand that I have the right to revoke this authorization at any time, provided that my revocation is in writing and conforms to requirements described in Notice of Privacy Practices.

6. LIMITS TO REVOCATION. I understand that my revocation will be effective upon its receipt by the person(s) I authorized in Section 1 but would not be effective to the extent that such persons have acted in accordance with this Authorization and in reliance thereon. With respect to the person(s) I authorized to receive and use health information described in Section 3, if patient (or personal representative) requested this Authorization, any revocation will be effective only when I communicate my revocation directly to them.

7. REDISCLOSURE. I understand that if the recipient of my information in Section 3 above is not a healthcare provider, a health plan or health care clearing house or not an entity required to comply with federal or state health privacy regulations, my health information may be further disclosed by such recipient and my information may no longer be protected by state and federal laws.

8. CALIFORNIA / ARIZONA RESTRICTION. I understand that a recipient of medical information in California or Arizona may not further disclose medical information about me (applicant/consumer) unless a new Authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.

9. RIGHT TO REFUSE TO SIGN. I understand that I do not have to sign this authorization and that my failure to sign this authorization will not affect my ability to obtain treatment, payment or benefits.

10. AUTOMATIC ONE-YEAR DURATION. This authorization will automatically expire after one (1) year from date of execution unless a different end date or event is specified below.

End date:	**or**	Event Name:

11. I have a right to receive a copy of this authorization.

☐ Please give me a copy of this request. _____ (initial)

Signed: _____ Relationship to Consumer:

Address:	Date:

NOTICE TO PROVIDERS OF INFORMATION:
All information you supply to ACRC is subject to Section 4514, Welfare & Institutions Code, Confidentiality and Disclosure. W&I Code §4514 allows for inspection of all records by the consumer, his/her parent/guardian or conservator. The information provided may be released by ACRC with the consent of the consumer or representative to other persons or agencies.

NOTICE TO RECEIVERS OF INFORMATION:
The information being released to you is confidential and subject to Section 4514, Welfare & Institution Code. You are prohibited from making any further disclosure of this information without the informed, written consent of the person to whom this information pertains or his/her parent/guardian or conservator.