San Diego Regional Center

Serving Individuals with Developmental Disabilities in San Diego and Imperial Counties

San Diego Regional Center (SDRC) provides support services for individuals with developmental disabilities. Developmental disabilities (DD) include autism, cerebral palsy, epilepsy, intellectual disability (formerly known as mental retardation), and conditions similar to intellectual disability or requiring support services like that of an individual with intellectual disability. The condition must originate prior to age 18, is expected to continue indefinitely and constitute a substantial disability to the individual. The information in this referral is kept confidential.

INQUIRY REQUEST FOR AGES 18 AND UP

INDIVIDUAL INQUIRING FOR SERVICES		
Last Name:	Date of Birth:	Sex:
First name:	Primary Language:	
Street Address:	Phone Number:	
City/State/Zip:		

DEVELOPMENTAL SERVICES		
1) Has the individual ever been evaluated by a regional center?	Yes	No
If yes, please state outcome of evaluation and services provided:		

2) Has the individual been diagnosed with a developmental disability? Please check applicable.		
Autism		*If other, what diagnosis was given?*
Intellectual Disability		
Cerebral Palsy		
Epilepsy		
Other:		

3) What documentation was used for diagnosis listed above? Please check applicable.		
IEP/School Evaluation		**For individuals over the age of 18, copies of documents must be submitted showing support of pre-age 18 diagnosis of the above identified developmental disability. Original documents will not be accepted.**
Developmental Evaluation		
Medical Report		
Other:		

REFERRING PARTY INFORMATION		
Full name:		
Relationship to applicant:		
Phone Number:		
Today's date:		
Does applicant give permission to have referring party speak on their behalf?	Yes	No
If yes, applicant must sign consent form attached to Inquiry Request with referring party name		

This inquiry request can be submitted to the Intake Department in the following ways:	
San Diego Regional Center Intake Department 4355 Ruffin Road San Diego, CA 92123	Fax: (858) 496-4302 Email: intake@sdrc.org
SDRC use only: Date received: _____________ UCI/Inquiry #: ___________ Processed By: ____________ SWS Completed: [ ]	

San Diego
Regional Center for the Developmentally Disabled

4355 Ruffin Road, Suite 110, San Diego, California 92123 · (858) 576-2996

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable information, as set forth below, consistent with California and Federal law concerning the privacy of such information.

USE AND DISCLOSURE OF INFORMATION:

Client's Name ______________________________ ______________________

Last First Middle Initial UCI# Date of Birth

I, the undersigned, do hereby authorize:

Name: San Diego Regional Center

Address: 4355 Ruffin Rd.

San Diego, CA 92123

Attention: ______________________________

To provide and/or request individually identifiable information (health, psychological, educational, etc.) in verbal or written format from the above-named person's record to and/or from:

Name: ______________________________

Address: ______________________________

____

Attention: ______________________________

The disclosure of this information is required for evaluation to determine my eligibility to receive services and/or to provide services to me.

EXPIRATION:
This Authorization expires one year from date of signature.

RESTRICTIONS:
California law prohibits San Diego Regional Center (SDRC) from making further disclosure of my information unless SDRC obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:
I understand that I have the following rights with respect to this Authorization:

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to: Custodian of the Records, San Diego Regional Center, 4355 Ruffin Road, San Diego, CA 92123.

My revocation will be effective upon receipt, but will not be effective to the extent that SDRC or others have acted in reliance upon this Authorization.

I have a right to receive a copy of this Authorization.

I do not have to sign this Authorization in order to receive services from San Diego Regional Center.

APPROVAL:

______________________________ ______________ ______________________
Client, Parent or Legal Representative Signature Date Witness (if applicable)

______________________________ ______________
Relationship to Client Area Code & Phone Number

Distribution:
Original: Source of Information
Copy: Client/Parent
Copy: File

SDRC003-Int (Rev. 05/18)

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Regional Center for the Developmentally Disabled

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AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable information, as set forth below, consistent with California and Federal law concerning the privacy of such information.

USE AND DISCLOSURE OF INFORMATION:

Consumer's Name ______________________________ ______________________
Last First Middle Initial UCI# Date of Birth

I, the undersigned, do hereby authorize:

Name: ______________________________

Address: ______________________________

____

Attention: ______________________________

To provide individually identifiable information (health, psychological, educational, etc.) in verbal or written format from the above-named person's record to:

Name: San Diego Regional Center

Address: 4355 Ruffin Rd

San Diego, CA 92123

Attention: ______________________________

The disclosure of this information is required for evaluation to determine my eligibility to receive services and/or to provide services to me.

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APPROVAL:

______________________________ ______________________ ______________________
Client, Parent or Legal Representative Signature Printed Name Date

______________________________ ______________________ ______________________
Relationship to Applicant Witness (If Applicable) Email, Area Code & Phone Number

SDRC #003 (Rev. 11/18)