WESTSIDE
REGIONAL CENTER

AUTHORIZATION FOR SERVICES

Date: _____

Consumer: _____

DOB: _____

I hereby authorize Westside Regional Center, the members of their professional staff, to perform upon the above named individual a medical, psychological or any other type of evaluation which is deemed necessary for a diagnostic assessment. These evaluations will provide the information that will make the determination of need for medical treatment, infant program and/or therapy; educational, vocational or any other appropriate services.

The authorization will remain effective for a period of two years or until revoked in writing and delivering to the Westside Regional Center.

_____ _____
Signature of Consumer (18 or over) Date

_____ _____
Parent, Guardian or Authorized Representatives of Consumer Date

_____ _____
Signature of Witness Date

_____
Relationship to Consumer