Privacy Officer, Utah Medicaid
PO Box 143102
Salt Lake City, Utah 84114-3102
Fax: (801) 536-0140

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

For the Division of Medicaid and Health Financing and the Department of Workforce Services

_____ _____ _____/_____/_____

Member Name **Member ID #** **Date of Birth**

I _____ hereby authorize the
(Member or Personal Representative Name)

Utah Department of Health, through its Division of Medicaid and Health Financing or the Utah Department of Workforce Services to **disclose** specific health information from the records of the above named member **to**:

_____
(Person or Organization Receiving the Personal Health Information)

_____
(Where to send the Information – Provide Address of Person or Organization)

The date range of the health information authorized for disclosure is: _____

The specific health information authorized for disclosure is: _____

_____

_____

The purpose for the disclosure is: _____

This authorization will expire on the following date, event, or condition: _____

I understand that if I do not provide an expiration date or condition, this authorization is only valid for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization at any time, by sending written notification to the Utah Medicaid Privacy Officer indicated above.

I understand that I may refuse to sign this authorization. The Division of Medicaid and Health Financing or the Department of Workforce Services cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this authorization.

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person or facility receiving it and may no longer be protected by federal or state privacy regulations.

By signing, I acknowledge I have been provided a copy of this signed authorization.

_____ _____
Signature of Member or Personal Representative* Date

*If signed by a Personal Representative, provide a description of authority to act on behalf of member:

_____

(Please attach documentation supporting legal authority of the person's appointment as a personal representative, if applicable (for example health care power of attorney, letter of guardianship, executor of estate, etc)