AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

TO

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

_____ _____ _____/_____/_____

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

I _____ hereby authorize the

(Member or Personal Representative Name)

_____

(Person or Organization Disclosing Information)

_____

(Address of Person or Organization Disclosing Information)

To disclose my personal health information to the Division of Medicaid and Health Financing or the Department of Workforce Services.

The specific health information authorized for disclosure is: _____

_____.

The purpose of the disclosure is: _____

_____.

I understand that this authorization will expire on the following date, event, or condition: _____

_____.

I understand that if I fail to specify an expiration date or condition, this authorization is 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 Person or Organization disclosing my personal health information.

I understand that I may refuse to sign this authorization. The Division of Medicaid and Health Financing or the Utah 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.

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

_____ _____

Signature of Member or Personal Representative* Date

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

_____