MEMBER REQUEST FOR PERSONAL HEALTH INFORMATION

Division of Medicaid and Health Financing
and
Department of Workforce Services

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

I _____ hereby request 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, disclose to me my own health information.

_____
(Where to send the Information – Provide Address of Member or Personal Representative)

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

The specific health information requested for disclosure:

_____

_____

_____

_____ _____
Signature of Member or Authorized 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)

Direct questions to:

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