Utah Department of
Health & Human Services
Integrated Healthcare

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
New Choices Waiver Program

Participant Name: _____ Medicaid ID#: _____ DOB: _____

Participant Phone Number: _____ Participant Email: _____

I, _____ , hereby authorize the New Choices Waiver Program (NCW) Office to disclose information, of the above-named participant to:

List names of individuals or entities below.	NCW will release any waiver related information unless otherwise indicated. Please note what cannot be released below:
Family: _____ _____ CMA: _____ Senior Planning Agency: _____ Other: _____	

I understand that:

- I may revoke this authorization at any time by sending written notification to the NCW.
- I may refuse to sign this authorization. The NCW cannot deny services if I refuse to sign this authorization.
- Information used or disclosed under this authorization may be subject to redisclosure by the person or facility receiving it and may no longer be protected by federal or state privacy regulations.
- The authorization cannot be revoked in response to information that has been acted upon by NCW.
- The authorization is valid for 1 year from the date of signature.

_____ _____

Signature of Participant or Personal Representative * Date

*** If signed by a Personal Representative, indicate the authority to act on behalf of the participant:**

☐ Legal Guardian (proof of guardianship required and submitted with this form)

☐ Personal Relationship (state relationship) _____

☐ Court Appointed Representative (state type of representative, proof required) _____

☐ Other _____

New Choices Waiver Program Office
P.O. Box 143112
Salt Lake City, UT 84114-3112
Fax: (801) 323-1586 Email: newchoiceswaiver@utah.gov