DWS-ESD 114AR
Rev. 07/2013

State of Utah
Department of Workforce Services

# AUTHORIZATION TO DISCLOSE MEDICAL ELIGIBILITY INFORMATION

D18216900550101

| Customer Name | Social Security # | Case # | Date of Birth |
|---|---|---|---|
| _____ | _____ | _____ | ____/____/____ |

I _____ hereby give
*(Customer or Authorized Representative)*

_____ the authority to:
*(Name of Individual or Organization)*

(check only one box)

☐ Receive Medicaid, CHIP, UPP, PCN or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed to whichever of the following occurs first:

- **The following date: _____; or**
- **The medical application is denied*; or**
- **30 days from the month the medical program is closed*.**

*If the application is denied or the case is closed, information disclosure will continue throughout the fair hearing process.

☐ Speak or act on my behalf as an authorized representative, which includes receiving Medicaid, CHIP, UPP, PCN or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed until a written notification to revoke the authorization is received by the Department of Workforce Services.

_____
**Address and Phone Number of Authorized Representative**

I understand that I may revoke this authorization at any time by sending a written notification to the Department of Workforce Services (DWS). I understand that a revocation is not effective to the extent that the Utah Department of Health, through its Division of Medicaid and Health Financing (DMHF) or the DWS has relied on the disclosed health information.

I understand my rights and responsibilities described in the Notice of Privacy Practices. For a duplicate Notice of Privacy Practices, access the following URL - http://health.utah.gov/hipaa/privacy.htm.

I understand that I may refuse to sign this authorization. I also understand that the DWS cannot deny eligibility for benefits if I refuse to sign this authorization.

I understand that giving an individual authorized representative power allows them to act on my behalf, which includes making changes to my medical case and any changes that they make, I may be liable for if an overpayment is incurred.

I understand that, once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by medical privacy laws and could be disclosed by the person or agency that receives it.
**Note: DMHF and DWS will not disclose controlled documents without the consent of their Legal Departments.**

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

_____/_____
Signature of Customer, legal guardian or Authorized Representative Date

If signed by other than the customer; description of authority to serve: _____

_____



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