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

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, indicated below to:

Select all that apply	NCW will release any waiver related information unless otherwise indicated. Please note any restrictions in what can be released below:
☐Senior Planning Agency_____ ☐Family_____ ☐CMA_____ ☐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, indicated the authority to act on behalf of the participant.**

☐Legal Guardian (proof of guardianship required)
☐Personal Relationship (state relationship) _____
☐Court Appointed Representative (state type of representative) _____
☐Other