Privacy Officer, Utah Medicaid
PO Box 143101
Salt Lake City, Utah 84114-3101

Utah Department of Health & Human Services
Integrated Healthcare

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

For Medicaid and Healthcare Financing, Division of Integrated Health, Utah Department of Health and Human Services

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

I _____ _____ hereby authorize the
(Member or Personal Representative Name)

_____
(Person or Organization Disclosing the Personal Health Information)

_____
(Provide Address of Person or Organization)

To disclose my personal health information to the Division of Integrated Healthcare or the Department of Workforce Serivces

The date range of the health information authorized for disclosure is: **Most recent clinic notes.**

The specific health information authorized for disclosure is: **Certification form, most recent visit notes, including Physical Exam, Medications, Problem List, Etc.**

The purpose for the disclosure is: **Medically Complex Children's Waiver / Technology Dependent Waiver Eligibility.**

This authorization will expire on the following date, event, or condition: **One year from signature date.**

I understand that if I do not provide an expiration date or condition, this authorization is only 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 Utah Medicaid Privacy Officer indicated above.

I understand that I may refuse to sign this authorization. The Division of Medicaid and Health Financing cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this authorization.

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person or facility receiving it and may no longer be protected by federal or state privacy regulations.

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

_____ _____
Signature of Member or Personal 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)