AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(For the Division of Health Care Financing to Disclose Information)

_____ _____ _____/_____/_____

Client Name **Social Security #** **Date of Birth**

I _____ hereby authorize the

(Client or Personal Representative)

Utah Department of Health, through its Division of Health Care Financing to disclose specific health information from the records of the above named client to:

_____.

(Person or Organization Receiving the Information)

The specific health information authorized for disclosure is: **Medicaid Employment-related Personal Assistance Services (EPAS program) eligibility and service file information.**

The purpose of the disclosure is: **to allow Medicaid Employment-related Personal Assistance Services (EPAS program) to freely share all information regarding:**

- **The client's current EPAS application, or**
- **The client's currently open EPAS case services, or**
- **The client's EPAS application/case which was denied/closed/ended on_____.**

I understand that this authorization will be effective the date this form is signed, and continue:

- **For an application that is approved—until the case is closed or services end, plus the time required to follow through with any appeal of the closure.**
- **For an application that is denied—until the case is denied, plus the time required to follow through with any appeal of the denial.**

I understand that if I fail to specify an expiration date or condition, this authorization is 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 Privacy Officer indicated in the Notice of Privacy Practices already provided to the client (a duplicate Notice of Privacy Practices can be provided upon request when filling out this authorization). I understand that a revocation is not effective to the extent that the Division of Health Care Financing or the Department of Workforce Services has relied on the disclosed health information.

I understand that I may refuse to sign this authorization. I also understand that the Division of Health Care Financing or the Department of Workforce Services 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, 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 redisclosed by the person or agency that receives it.

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

_____/_____

Signature of Client or Authorized Representative Date

If signed by an Authorized Representative, a description of authority to serve: _____