HCF-BES 114AR
5/06

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(For disclosure by Health Care Financing, and the Department of Workforce Services)

_____	_____	____/____/____
Client Name	**Social Security #**	**Date of Birth**

I _____ hereby authorize the
(Client or Authorized Signer.)

Utah Department of Health, through its Division of Health Care Financing or the Department of Workforce Services to disclose **Medicaid eligibility file information** from the records of the above named client to:

_____
(Name of Authorized Representative – this may be the name of an organization)

The purpose of the disclosure is: **to allow Medicaid to freely share all information regarding:**

- **the clients current Medicaid application, or**
- **the client's currently open Medicaid case, or**
- **the client's Medicaid application/case which was denied/closed 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, 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 I may revoke this authorization at any time, by sending written notification to my case worker. 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 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 Signer Date

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

_____.