Utah Department of
Health & Human Services
Integrated Healthcare

# MCCW AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

To The Division of Integrated Healthcare or The Department of Workforce Services

_____ _____ ____/____/____

Member Name (Child) Medicaid ID # Date of Birth

I, _____, hereby authorize

*(Parent or Personal Representative Name)*

_____,

*(Name of Provider or Clinic Disclosing Information)*

_____

*(Address and fax number of Provider or Clinic Disclosing Information)*

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

The specific health information authorized for disclosure is: Medically Complex Children's Waiver Physician Certification form, most recent visit notes, including Physical Exam, Medications, Problem List, Etc.

The purpose of the disclosure is: Medically Complex Children's Waiver eligibility determination.

I understand that this authorization will expire on the following date, event, or condition: 60 days from signature date.

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 the Person or Organization disclosing my personal health information.

I understand that I may refuse to sign this authorization. The Division of Medicaid and Health Financing or the Utah 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.

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 the member:

_____

_____