DWS-OSD 114AR
Rev. 5/2008

State of Utah
Department of Workforce Services

AUTHORIZATION TO DISCLOSE MEDICAID ELIGIBILITY INFORMATION

Customer Name	Social Security #	PID	Date of Birth
			/ /

I ____ hereby authorize the
(Customer or Authorized Representative)

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

____
(Name of Authorized Individual or Organization Receiving the Information)

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

- **The client's current Medicaid application, or**
- **The client's currently open Medicaid case, or**
- **The client's Medicaid application/case, which was denied/closed on ________.**

This authorization is effective from the date this form is signed, and:

- **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 caseworker. 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 also understand my rights and responsibilities described in the Notice of Privacy Practices I have received. For a duplicate Notice of Privacy Practices, access the following URL - http://health.utah.gov/hipaa/privacy.htm.

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.
Note: DWS does not disclose controlled documents without consent of the DWS Legal Department.

By signing this form, I designate the above named person or organization as my representative and authorize the disclosure of information in my file as described above. I acknowledge I have been provided a copy of this signed authorization.

____/________________
Signature of Customer or Authorized Representative Date

____/________________
Signature of Parent or Guardian, if under age 18 Date

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

____.

Equal Opportunity Employer Program
Auxiliary aids and services are available upon request to individuals with disabilities by calling (801) 526-9240. Individuals with speech and/or hearing impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162