Utah Department of Health & Human Services

Authorization to furnish information and release from liability

Form 1-2
Version Date: February 2025

Privacy Notice: See the end of this form to learn why DSPD is collecting this information.

Name: _____ Date of Birth: _____

The following have my permission to disclose my protected health information:

- ☐ School District
- ☐ Vocational Rehabilitation
- ☐ Mental Health Provider
- ☐ Physician
- ☐ Other

You are hereby authorized to release to the **Department of Human Services Division of Services for People with Disabilities (DSPD)** or its authorized representatives, verbally or in any written form, any information you have regarding the following subjects:

- ☐ Developmental testing
- ☐ Psychological/cognitive tests
- ☐ Outpatient records
- ☐ Inpatient records
- ☐ Brain Injury records
- ☐ Physical examination records
- ☐ Vocational testing
- ☐ IEP/educational testing
- ☐ Other _____

Please include records from _____ to _____

(Recipient Information: If the information released relates to drug or alcohol abuse, the records are protected by federal confidentiality laws and you are prohibited from making further disclosures of this information without the specific written authorization of the person of whom it pertains or as permitted by 42 CFR Part 2. A general authorization for the release of information is NOT sufficient for this purpose. Federal law restricts using drug or alcohol abuse information for criminal investigation or prosecution.)

The purpose of this disclosure is to establish eligibility for DSPD services. Disclosure Expiration Date: _____

- I understand that I may refuse to sign this Authorization, and my health care provider cannot refuse to provide treatment, payment or deny eligibility for benefits based upon my refusal.
- I understand that I may revoke this authorization in writing at any time. I understand that my revocation is not effective until received by the health care provider. My revocation is not effective to the extent the health care provider already released information in reliance on this authorization.
- I understand that federal privacy laws may no longer protect information released to DSPD and the information may be re-disclosed.
- I understand that this information is required by the Department of Human Services Division of Services for People with Disabilities.

I, the Individual and/or Authorized Personal Representative, understand that by signing below am requesting the Division of Services for People with Disabilities to collect information about me to see if I am eligible for services.

Signature: _____ Date: _____

Signer is: ◯ the individual named above ◯ the individual's legally authorized personal representative

Authorized personal representative's name: _____

Privacy notice

The information you provide will be used to determine eligibility for division services. It will only be used by DHHS and, if needed, by a person or party contracted with DHHS. Without this data, we cannot make a determination. This data is part of record series: 15376.