utah department of human services
Division of Services for People with Disabilities

Authorization to Furnish Information and Release from Liability

Name:_____ DOB: _____

I am: ☐ The individual named above ☐ The individual's legally authorized personal representative

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

☐ School District:_____
☐ Division of Rehabilitation Service:
☐ Mental Health Centers listed: _____
☐ Physicians and Psychologist as listed:
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 ☐ Brain Injury Records ☐ Vocational Testing
☐ Psychological/Cognitive Tests ☐ Inpatient /Outpatient Records ☐ IEP/Educational Testing
☐ Outpatient Records ☐ Physical Examination Records ☐Other:_____

Please include records from: _____ to _____

(*Recipient Information: If the information released related 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 ☐ Expiration Date (please specify):_____

- 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 for the 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.

Individual's Name *(printed)*: _____

Individual's Signature/Date: _____

Authorized Personal Representative's Name *(printed)*: _____

Authorized Personal Representative's Name *(printed)*: _____