Ver. Feb. 2024

Utah Department of
Health & Human Services
Services for People with Disabilities

Authorization to Disclose Protected Health Information

All parts of this form must be completed. Authorized personal representatives must attach a copy of the legalizing court document appointing the personal representative if not already on file with DSPD.

Name:_____ Date of Birth:_____

I am:

- ☐ The individual named above
- ☐ The individual's legally authorized personal representative

The Utah Division of Services for People with Disabilities (DSPD) has my permission to disclose my protected health information to the following:

_____

The purpose of this disclosure is:

_____

List the information that is authorized to be shared:

_____

_____

- ☐ Check this box if this release permits DSPD to release your information to the media.

This authorization expires on (please specify date): _____

- I understand that I may refuse to sign this Authorization, and DSPD 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 DSPD.
- My revocation is not effective to the extent that DSPD already released information in reliance on this authorization.
- I understand that federal privacy laws may no longer protect information released by DSPD and the information may be re-disclosed.

I, the individual and/or Authorized Personal Representative, understand that by signing below I am giving the Division of Services for People with Disabilities permission to release my protected health information as defined above.

Individual's Name (printed):_____

Individual's Signature:_____ Date:_____

Authorized Personal Representative's Name (printed):_____

Authorized Personal Representative's Signature:_____Date:_____