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

Authorization to disclose protected health information

HIPAA

Version: 10/2025

Privacy statement: The information you provide will be used to review and process requests to disclose protected health information. It will only be used by DHHS and, if needed, by individuals or parties contracted with DHHS. Without this data we cannot review and process requests to disclose protected health information. This data is part of record series: 15376.

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: _____

☐ 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 if applicable): _____

- 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: _____