HEALTH | CHOICE
UTAH

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Information

Member Name _____ Member ID# (on ID Card) _____

Date of Birth _____ Phone # (_____) _____

Member Address _____

_____

Information to be Disclosed

I request and authorize Health Choice Utah to DISCLOSE my protected health information:

Please circle to indicate your selection: All/Full Record Other/Please indicate: _____, _____, _____

Recipient Information

I authorize the following person(s) or organization to access my member information:

Name: _____ Relationship: _____

Please indicate the purpose of the disclosure of your member records: _____

This authorization expires (circle one)

One time disclosure One Year Other / Please indicate: _____

If applicable, I understand that based on the information I have designated above; the disclosure Health Choice makes pursuant to this authorization may include information regarding my participation in a substance abuse treatment program.

I understand that if the authorized recipient of this information is not a health care provider or health plan covered by federal privacy regulations, the information he/she receives will no longer be protected by these regulations, and the recipient may re-disclose the information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that Health Choice will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: Health Choice Utah – Mail: PO Box 45900, SLC UT 84145 / Email: cobandeligibility@healthchoiceutah.com / Fax: 801-646-7210 / Phone: 877-358-8797

I understand that my revocation is not effective to the extent that action has been taken in reliance on this authorization.

Signature **Date**

If Applicable, Printed Name of Personal Representative _____

Description of Personal Representative Authority: Parent ___ Power of Attorney ___ (attach documentation) Other ___ (attach documentation)

Return completed forms to Health Choice Utah – Mail: PO Box 45900, SLC UT 84145 / Email: cobandeligibility@healthchoiceutah.com/ Fax: 801-646-7210