THE UNIVERSITY OF UTAH

Human Resources Division – Benefits Department

420 Wakara Way, Suite 105 Salt Lake City, Utah 84108
Phone: (801) 581-7447 Fax: (801) 585-7375

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____
Employee ID Number: _____
Social Security Number[1]: _____
Address: _____
_____
Daytime Phone: _____

I hereby authorize the University of Utah Health Care Plan and the University Benefits Department to use or disclose my health information as described in this Authorization. This Authorization is voluntary and I may refuse to sign it. I understand that my eligibility for, enrollment in, or payment of benefits under the University Health Care Plan are not conditioned on this Authorization. I may inspect or copy any information used or disclosed under this Authorization.

A specific description of the health information that I am authorizing to be used or disclosed is:

_____
_____
_____
_____

The name or other specific identification of the person or organization I am authorizing to receive the health information is: _____
Address: _____.

The purpose for which I am authorizing the use and disclosure of the specific health information is:

- ☐ For my own personal use.
- ☐ Other: _____
  _____.

I understand that based on the dates, providers, and information I have designated above, the disclosure made pursuant to this authorization may include information regarding my participation in a substance abuse treatment program, if any. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

[1] Providing your social security number is voluntary. Failure to provide this information may delay the processing of your request.

I understand that if the authorized recipient of my health 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 that the information may be redisclosed by the recipient.

This authorization (please check one): ☐ is for a one-time disclosure only; or ☐ will expire on the following date or event: _____

_____.

I understand that I may revoke this Authorization at an earlier date by sending a written notification to the University Benefits Department. I also understand that my revocation will be effective when received, but that any use or disclosure occurring before receipt of my revocation will not be affected or if action has been taken in reliance on the Authorization, I will not be able to revoke the Authorization with respect to subsequent uses and disclosures in connection with that action.

Dated: _____

_____

Member or Member's Representative[2]

University of Utah Benefits Department

_____

Witness (if Member appears personally and presents valid identification)

_____

(Notary is required if the member does not appear personally at the University Benefits Department and present identification)

SUBSCRIBED AND SWORN to before me this _____ day of _____, 20___.

_____

NOTARY PUBLIC

Residing in: _____

My Commission Expires: _____

[2] If signing as a member's representative, you must describe your authority to act for the member and provide documentation showing authority.