HEALTH | CHOICE
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Attached is the authorization to disclose personal health information form you requested. You may take back “revoke” your written permission at any time. You may revoke authorization in writing to the address noted below or by calling member services.

If you are requesting personal health information for a deceased beneficiary, please include a copy of the legal documentation which indicates your authority to make a request for information.

Acceptable documentation:

- Executor/Executrix papers
- Next of Kin attested by court documents with a court stamp and a judge signature
- Letter of Testamentary or Administration with a court stamp and judge signature
- Personal representative paper with court stamp and judge signature

Where to return your completed authorization form:

Health Choice Generations Utah
PO Box 45900
Salt Lake City, UT 84145

Please call Health Choice Generations Utah at 1-844-457-8943 if you have any questions. TTY users should call 711. We are open seven days a week, from 8AM to 8PM.

Thank you for your continued membership in Health Choice Generations Utah HMO D-SNP is a Health Plan with a Medicare contract and a contract with the state Medicaid program. Enrollment in Health Choice Generations Utah HMO D-SNP depends on contract renewal.

This information is available in other formats, such as Braille, large print, and audio.

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Health Choice Generations Utah will only disclose the personal health information you want disclosed. Use this form if you want Health Choice Generations Utah to give your personal health information to someone other than you.

<table>
<tr><td colspan="2">First Name: Middle Initial: Last name</td><td>Birth Date:</td></tr>
<tr><td>Member Number:</td><td colspan="2">Home Phone Number:
(   )</td></tr>
</table>

Check only **<u>one</u>** box below indicating how long Health Choice Generations Utah can use this authorization to disclose your personal health information.

☐ Disclose my personal information indefinitely

☐ Disclose my personal information for a specified period only

Beginning: ____________ (mm/dd/yyyy) **Ending: ____________ (mm/dd/yyyy)**

Personal Representative: ____

Birth Date: ____

Address: ____

Phone number: ____

Relationship to Member: ____

☐ Check here if you are signing as a personal representative. Please attach the appropriate documentation which indicates your authority to make a request for information, for example legal power of attorney.

I understand that by signing this form I authorize Health Choice Generations Utah to disclose my personal health information to the person(s) I have named on this form.

Your Signature*: ______________________________ **Date:** __________________

Health Choice Generations Utah HMO D-SNP
PO Box 45900 • Salt Lake City, UT 84145
Phone: (844) 457-8943 • TTY: 711 • www.HealthChoiceGenerations.com