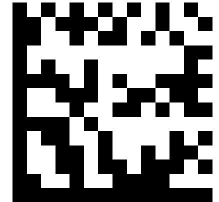
DWS-ESD/WDD 114MC
Rev. 11/2012

State of Utah
Department of Workforce Services

myCase AUTHORIZATION TO RELEASE INFORMATION TO A THIRD PARTY



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Name: ____ Case Number: ________________________

I authorize the Department of Workforce Services and/or the Department of Health, Division of Medicaid and Health Financing to Release the information contained in the myCase database to the following third party:

LIST THE NAME OF THE PERSON/ORGANIZATION BEING ALLOWED ACCESS: ____

1. **I am granting the above-named Third Party access to my myCase information as follows: (CHECK ALL THAT APPLY)**

   ☐ "**View**:" I am granting access to view my case information only. The third party may view my information relating to the following assistance programs:

   ☐ All Programs ☐ Child Care ☐ Financial Assistance ☐ Food Stamps ☐ Medical Assistance

   ☐ "**Full Access**:" I am granting access to update, alter, or otherwise make changes to my information, as well as view all case information. This also includes completing and signing my case review.

   ☐ "**Notices**:" I am granting access to view any notice that was sent to me by the Department, regardless of the type of benefits I will, or have received.

   ☐ "**Verifications**:" I am granting access to view any request for verification that the Department has asked me to provide, regardless of the type of benefits that I will, or have received.

2. The third party may have access to my information for the following purpose: ____

3. I understand that I am not required to grant access to any third party. I also understand that the Department of Workforce Services and/or the Division of Medicaid and Health Financing cannot deny eligibility if I refuse to grant access to a third party.

4. I understand that I will be responsible for any overpayments that may occur as a result of incorrect information being provided by an individual that I authorized to update, alter or make changes to myCase information.

5. I understand that I can choose to grant view only or full access to members of my household.

5. I understand I can choose to grant view only or full access to individuals who are not members of my household, such as my primary care physician or other healthcare providers.

6. By granting access to myCase, I specifically authorize the Department of Workforce Services to share all information regarding my case, including my medical applications, medical cases, and any medical application or case which was denied or closed to the above-named third party. I understand that if there is anything in my case that I do not want shared, I must not grant access to my case.

7. The Department may share limited information with my child care provider(s) through the provider website. If I choose to grant my child care provider access to view my case information, I specifically authorize access to information as it pertains to child care benefits to be paid to them for services provided. I understand if I grant my child care provider access to notices and/or verifications, the provider will be able to view any notice and/or verification regarding all benefits I receive, or have received.

8. I understand that once information is shared because of this authorization, it is possible that it will no longer be protected by privacy laws and could be re-disclosed by the person or agency that receives it.

9. I understand that the Department of Workforce Services and the Department of Health cannot control the information once it has been released to the above-named third party. As such, I specifically release the Department of Workforce Services and the Department of Health or any other state agency from any liability that may accrue as a result of the release or sharing of my information with those parties I have authorized to view, alter, or amend my information.

10. I understand that I may revoke this authorization at any time by removing authorization through my "myCase" account or by sending written notification to my Department caseworker. I also understand that a revocation will not change the fact that information may have already been shared before I revoked my consent. I also understand that the Department or another state agency may have relied on and acted on such information and that revocation may not affect the results of such action.

11. I understand that this authorization is effective from the date authorization is granted, until 12 months from the date granted, or until I revoke access in myCase or provide written notification to my Department caseworker, whichever is sooner.

    Access will be granted within one (1) business day.

____ ____________________

Customer Signature — Date

__________________________________ __________________ ____________________

Signature of Third Party — MC# — Date

Equal Opportunity Employer Program

Auxiliary aids and services are available upon request to individuals with disabilities by calling (801) 526-9240. Individuals with speech and/or hearing impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162.