

UTAH SSDI '1 FOR 2' PROJECT

Authorization to Disclose Information

Name _____ Social Security # _____ Date of Birth _____

Purpose

The authorization to release and disclose information is to facilitate the administration and evaluation of the Utah SSDI '1 for 2' project. This requires information about my employment, use of services from federal and Utah agencies and specific health information.

Consent

I authorize the release of my program records, as indicated by my signature below, to the Utah SSDI '1 for 2' Project team. This authorization is valid for events occurring from January 1, 2000 until the project terminates or at the latest to December 31, 2010. I have been informed that these records will be obtained based on my name, Social Security number and date of birth.

- I authorize the **Social Security Administration (SSA)** to prepare a Benefits Planning Query (BPQY) and send it to the Utah State Office of Rehabilitation (USOR) Benefits Planning program. I also authorize SSA to conduct a work continuing disability review (Work CDR) if I was employed and my records indicate use of Trial Work Period months or other work incentives. I authorize SSA to release data to the Utah SSDI '1 for 2' Project team from my Master Benefit Record and Disability Control File. I understand that the information will be used solely for participation in the Utah SSDI '1 for 2' project.
- I authorize the **Utah State Office of Rehabilitation** to release data on vocational rehabilitation services I received (if applicable), including dates of service, categories of service, status at closure and cost of services. I also authorize the Utah State Office of Rehabilitation to release data on benefits planning services I received (if applicable), including but not limited to date of referral, date of benefits analysis, and work incentive provisions recommended.
- I authorize the **Utah Department of Workforce Services** to release my employment wage data from Unemployment Insurance records. I also authorize the Utah Department of Workforce Services to release data on Food Stamps, Family Employment Program (FEP) and General Assistance (GA) cash benefits and training services I received (if applicable), including dates of eligibility, amounts of assistance and training cost and type.
- I authorize the **Utah Department of Health Division of Health Care Financing** to disclose specific health information from my Medicaid records. The information authorized for disclosure is: dates of Medicaid eligibility, categories of aid, and cost of Medicaid services.

- I authorize **Valley Mental Health** or **Bear River Mental Health** to disclose specific health information on services I received, if applicable. The information authorized for disclosure is: dates of services, service codes and cost of services.
- I authorize _____ and/or _____ to release information on services I have received from this agency. The type of information to be released includes dates of service, types of service and cost of services.

Once it is released, the health information is no longer protected by medical privacy laws, and could be re-disclosed by the person or agency that receives it.

Transfer of the Records to Other Parties

I understand that data collected about me for this Project will be kept confidential and will not be transferred to other parties outside the Project team. The SSDI ‘1 for 2’ Project team includes staff from the Utah Department of Health, the University of Utah, Utah State University and Utah State Office of Rehabilitation. All Project team members are obligated to meet the confidentiality and data protection requirements of each state and federal agency from which it receives data.

The SSDI ‘1 for 2’ Project team will destroy all personal identifiers in the data following the completion of the project. If I have any questions about this form or the Utah SSDI ‘1 for 2’ Project, I can call the project team at 1-877-2GO-WORK or 1-877-246-9675.

Withdrawal from Project

I may choose to withdraw from the Utah SSDI ‘1 for 2’ Project at any time resulting in the withdrawal of this Authorization form. To withdraw I would need to complete a Withdrawal from Project Form.

Acknowledgement

I am the individual to whom the information/record applies or their legal guardian, and I understand that any false representation to knowingly and willfully obtain information from SSA records is punishable by a fine and/or imprisonment. I confirm that I have read and understand this Authorization form. I understand that my involvement is voluntary. I am free to withdraw at any time, without giving a reason, and without my rights being affected.

By signing I acknowledge I have been provided a copy of this signed Authorization.

Signature of Enrollee

Date

Signature of Legal Guardian (if applicable)

Date

Enrollment Specialist’s signature

Date