**Designation of Authorized Representative**

|  |  |  |
| --- | --- | --- |
| Member Name (*please print*) | Date of Birth | Member ID number |
|  |  |  |
| Member's Street Address | City  | State | Phone  |
|  |  |  |  |
| Name of Individual/Company/Law Firm being designated as the authorized representative |
|  |
| Designated Representative's Address  | City | State | Phone |
|  |  |  |  |
| Provider of Service |
|  |
| Date(s) of Service or Proposed Service |
|  |

I, \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_, do hereby name

 *Print the name of the member who is receiving the service or supply*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Print the name of the person who is being authorized to act on the member's behalf*

to act as my authorized representative in requesting (*check all that apply*)

a complaint an appeal documents

from UnitedHealthcare regarding the above-noted service or proposed service.

**I understand and agree that:**

* This authorization is voluntary;
* my health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information:
* I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
* my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulation;
* this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying UnitedHealthcare in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

|  |  |
| --- | --- |
| Signature of Member | Date |
|  |  |
| If person signing this authorization is not the member, describe relationship to the Member(i.e. Parent, Legal Representative) |
|  |