Authorized Representative Designation Form

Applicant or Enrollee's name (First name, Last name)		
Mailing address		
City	State	ZIP code
Telephone Number	SSN	Date of Birth (mm/dd/yyyy)

CHECK ONE

The person or organization below is my authorized representative for **all matters** related to my account. ☐

The person or organization below is my authorized representative only to **act as my representative during an appeal.** ☐

By signing, you allow this person or organization to get official information about your account and act for you for the matters you stated above. Your authorization will become effective when we receive this completed form, and it will remain effective until you or your authorized representative tell us that the authorization has ended.

Applicant or Enrollee's signature	Date (mm/dd/yyyy)

Acceptance of Designation

Authorized representative's name (First name, Last name, or Organization name)		
Mailing address		
City	State	ZIP code
Telephone number		☐ Attorney ☐ Non-attorney representative

By signing, you agree to maintain the confidentiality of any information regarding the applicant or enrollee that NY State of Health provides. You also agree to fulfill all the responsibilities encompassed within the scope of this authorization as if you were the applicant or enrollee. You also agree to comply with applicable state and federal laws concerning conflicts of interest.

If you are signing on behalf of an organization, you agree that providers, staff members, and volunteers affirm that they will comply with applicable state and federal laws concerning conflicts of interest and confidentiality of information.

Representative's Signature	Date (mm/dd/yyyy)

NEED HELP WITH THIS FORM? Call us at 1-855-355-5777.
TTY users should call 1-800-662-1220 or 1-877-662-4886 for TTY in Spanish.