KAISER PERMANENTE®

Kaiser Permanente Insurance Company(KPIC)

STATEMENT OF AUTHORIZED REPRESENTATIVE – Page 1 of 2

I understand that Kaiser Permanente will not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this authorization.

PART A: If you wish to give authority to another party to file a complaint, grievance, Medicare Review, or an appeal on your behalf, please complete the following information. If you wish this person to receive Protected Health Information (PHI) regarding your treatment and care, you must check the appropriate box(es) and you and your representative must both sign and date this form. **Please return the completed form to the requester who is handling your case.**

Your Name and Address

Daytime Phone #	Alternate Phone #
Medical Record #	Medicare #

PART B: I hereby authorize the person named below to represent me regarding concerns with the quality of care or service I have received that are provided through my employer group coverage that is administered by Kaiser Permanente Insurance Company (KPIC). I understand that this authorization is voluntary and, if I choose to do so, I have the right to revoke it in writing to KPIC and to my designated representative. KPIC and my designated representative will no longer use or disclose my PHI, except to the extent KPIC or my designated representative has taken action in reliance upon this authorization.

Name of Designated Person		
Address		
City	State	ZIP Code
Daytime Phone # ( )	Evening Phone # ( )	

☐ I authorize Kaiser Permanente Insurance Company to disclose Protected Health Information regarding my medical condition and care and/or payment information to the above named individual. This information must be relevant to the request filed with KPIC on _____ (date of request).

SPECIFY Check the box and initial to specify which type of authorization is to be disclosed:

RECORDS: ☐ **MEDICAL INFORMATION**_____ INITIAL

☐ **PSYCHIATRIC INFORMATION**

_____ _____
SIGNATURE DATE

☐ **DRUG/ALCOHOL INFORMATION**

_____ _____
SIGNATURE DATE

☐ **RESULTS OF AN HIV BLOOD TEST**

_____ _____
SIGNATURE DATE

☐ **OTHER HEALTH INFORMATION** (specify below)

Specify the records to be disclosed:_____

_____

_____

☐ This authorization shall become effective immediately and shall remain in effect until the earlier or final resolution of my request or _____(specify date).

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REVOCATION: This Authorization is also subject to written revocation by the insured/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health Information unless another authorization is obtained from make or unless such use or disclosure is specifically required or permitted by law.

Your Signature:_____ **Date:**_____

PART C:

I am authorized to sign this authorization on behalf of _____ and on the basis of:

☐ Legal Authority (Power of Attorney, etc.) ☐ Written Designation by Insured/Patient

☐ Parent, Guardian, or other individual acting in loco parentis

Authorized Representative:_____ **Date:**_____

Patient has a right to a copy of this form.