**Authorized Representative Form**

An Authorized Representative is a trusted person who would be given permission to talk about an application or appeal request with us, see your information, and act for you on matters related to the application or appeal, including getting information about your application or appeal. This person takes legal responsibility for the information provided on your application or appeal request. If you do not want an authorized representative, you do not need to fill out this form.

Retiree Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize the below named representative to sign your application or appeal request, get official information about this application or appeal request, and act for me on all future matters with this agency from today until:

NO End Date **or** End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Authorized Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Retiree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number (please circle home/cell/work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I understand the following: See CFR §164.508(c)(2)(i-v)

1. My Authorized Representative is permitted to receive my protected health information to the extent permitted by this Authorization. I understand that protected health information is individually identifiable information relating to the past, present, or future health status that is created, collected, transmitted, or maintained by a HIPAA-covered entity in relation to the provision of healthcare, payment for healthcare services, or use in healthcare operations.
2. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
3. My treatment, payment, enrollment, or eligibility for benefits cannot be conditioned on the signing of this authorization.
4. Any facsimile copy or photocopy of the authorization shall authorize my representative to release the records requested herein.
5. The information released in response to this authorization may be re-disclosed by my authorized representative to other parties and no longer be protected by this authorization.

**Signature of Retiree or Legally Authorized Representative:**

**(See 45CFR § 164.508(c)(1)(vi))**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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