Designation of Authorized Representative

Member's name (please print):	Date of birth:

Member's street address:

City:	State:	ZIP code:

Designated representative's address:

City:	State:	ZIP code:

Provider:	Date(s) of service or proposed service:

I _____ , am appointing

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

Print the name of the person/organization who is being authorized to act on the member's behalf:

To act on my behalf as my authorized representative for (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 be disclosed to my authorized representative and 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, 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 2 years 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 or approved party:	Date:

If person signing this authorization is not the member, describe relationship to the member (i.e., parent, legal representative):

United Healthcare®