

## Designation of Authorized Representative

Use this form to appoint someone as your Authorized Representative. When you appoint someone as your Authorized Representative, they can act on your behalf. They will also have access to your protected health information (PHI) as it relates to the topic you specify below. Please note we cannot share any information about you with someone else, nor can someone else act on your behalf, unless we receive a signed copy of this form.

Claimant Name (print)	Member ID #
	Plan to recognize the person named below as my representative nd to disclose relevant health information to:
(Name of person representing you)	(Telephone Number)
(Street Address)	(City, State, Zip Code)
All Medical claims	All Dental claims
All Appeals	Other (please be as specific as possible):
such information as confidential. I un Authorized Representative Form to	does not ensure that the person I am authorizing to receive health information about me will treat inderstand that I may revoke this Authorization at any time by submitting a Cancellation of St. Luke's Health Plan. This Authorization is valid for one year following the date on which it is ration date or event is indicated here or upon receipt by St. of Authorization Form.
Claimant's Signature	Date

A copy of this authorization form will be sent to your designated representative at the address listed above.