

Appointment of Representative and Authorization to Release Health Information

My Name:			
Mailing Address:			· · · · · · · · · · · · · · · · · · ·
Phone Number:			
Signature of Member/Patient	Print Name	Date	
uthorization to Release He	alth Information for Appe	als, Claims, or Complain	nts
enetic information is not requested	by, used or disclosed by Kaise	r Permanente for underwriting	purposes.
I authorize Kaiser Permanente to complaint, claim, or appeal includ			
I understand I do not have to sign		•	
enrollment, or eligibility for benefits			
care is to create health information			
I understand that I may revoke this			
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Keep a copy for your records and submit the original to: Kaiser Permanente Appeals, P.O. Box 34593, Seattle, WA 98124-1593. Please contact Member Appeals at 1-866-458-5479 if you need a copy of this form.