KAISER PERMANENTE®

Appointment of Authorized Representative

Complete this form if you want to name someone to act on your behalf. Be sure to complete all required sections. Please fax it to us at **808-432-5260**, or mail it to us at:

Kaiser Permanente
Hawaii Grievance and Appeals Operations
711 Kapiolani Blvd
Honolulu, HI 96813

PART A: Patient/Member Information (Required)

First Name	Last Name	
Street Address		
City	State	Zip Code
Daytime Phone	Alternate Phone	Medical Record Number

PART B: Authorized Representative Information (Required)

First Name	Last Name	
Street Address		
City	State	Zip Code
Daytime Phone	Alternate Phone	

PART C: Protected Health Information (Required)

Kaiser Permanente may share protected health information about my medical condition, treatment, and/or payment with my authorized representative. I understand Kaiser Permanente will only share information relating to my complaint, appeal, or claim. Specifically, Kaiser Permanente may share: **(check at least one)**:

☐ Medical Records/Information ☐ Drugs/Alcohol ☐ Behavioral/Mental Care ☐ HIV Test Results
☐ Other (please specify): _____ OR
☐ Kaiser Permanente may not share protected health information with my authorized representative.

YOUR SIGNATURE: _____ DATE: _____
(Please sign here AND in Part D)

PART D: Signature (Required)

I authorize the person named in Part B to represent me regarding concerns with my care or coverage. I understand that signing this form is voluntary, and that I do not have to sign it to get treatment, payment, enrollment, or benefits. I have the right to withdraw this authorization at any time by giving written notice to Kaiser Permanente. I understand that withdrawing this authorization will not affect any action taken before I do so. I understand this form is only valid until my case is resolved. If I file a new case, I will need to complete another statement of authorized representative form.

YOUR SIGNATURE: _____ DATE: _____

(Check one)

❒ I am the patient/member

❒ The patient/member is my minor child (child under 18 years old)

❒ I have authority to sign this on the patient/member's behalf
(*If this option is checked, please complete Part E, below*)

PART E: Designated Legal Representative/Guardian

Fill out this section if you are a legal representative signing this form on behalf of the patient/member. **You must include a copy of a court order or other document reflecting your authority to act on the patient/member's behalf, such as a Health Care Power of Attorney.**		
Legal Representative First Name		
Legal Representative Last Name		
Street Address		
City	State	Zip Code
Daytime Phone	Alternate Phone	
Legal Relationship to Member		
I have attached the following document which reflects my authority to act on the patient/member's behalf: (**briefly describe**) _____		
LEGAL REPRESENTATIVE SIGNATURE: _____ **DATE: _____**		