KAISER PERMANENTE®

Appointment of Representative and Authorization to Release Health Information

I designate Amanda Orewiler PO BOX 865539 Orlando FL 32886 Provider Office Billing Dept Rep
Print name of representative Mailing address Relationship
to act as my representative for purposes of requesting a coverage appeal, payment of a claim, or submission of a complaint on my behalf.

My Name: _____

Mailing Address: _____

Phone Number: _____ Date of Birth: _____ ID#: _____

Signature of Member/Patient Print Name **Date**

Authorization to Release Health Information for Appeals, Claims, or Complaints

Genetic information is not requested by, used or disclosed by Kaiser Permanente for underwriting purposes.

- I authorize Kaiser Permanente to disclose to the representative designated above, information relevant to my complaint, claim, or appeal including, but not limited to, medical records and coverage information.
- I understand I do not have to sign this authorization to get health care benefits (treatment, payment, enrollment, or eligibility for benefits) except if I receive health care when the sole purpose of the health care is to create health information for a third party.
- I understand that I may revoke this authorization at any time by sending a written statement to the mailing address at the bottom of this form. I further understand that if I revoke my authorization, it will not affect any actions already taken by Kaiser Permanente based on this authorization; and I may not be able to revoke this authorization if the purpose of it was to obtain insurance.
- I understand that once Kaiser Permanente has disclosed health information, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information.
- This authorization expires _____ (date or event). Authorization will expire in 12 months if not specified.

Specific authorization is required to release information pertaining to the health care information listed below. By initialing and describing the information to release, I authorize release of the information pertinent to my appeal, claim or complaint relating to testing, diagnosis or treatment for:

_____ Chemical Dependency _____ Mental Health _____
Initials Describe/Date Range Initials Describe/Date Range

_____ HIV/STD/AIDS _____ Reproductive Care (minors only) _____
Initials Describe/Date Range Initials Describe/Date Range

MINORS – A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

Amanda Orewiler Provider Office Billing Dept Representative

Signature of Representative **Date** **Relationship**

☐ Check if patient is a minor

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.