AlohaCare
For a healthy Hawaii.

APPOINTMENT OF REPRESENTATIVE

Date: **Member number:**

Name: **Reference/Case number:**

PART 1 --- APPOINTMENT OF REPRESENTATIVE (to be filled out by Member)

I allow _____ to act for me when filing a
(Name of person you want as your representative)
grievance, claim or appeal.

The person I have named can act for me when giving or receiving any information about my grievance, claim or appeal. This includes personal medical information.

Member:	Date:
Street Address:	Telephone (with area code):
City:	State: ZIP Code:

PART 2 --- ACCEPTANCE OF APPOINTMENT (to be filled out by Representative)

_____ , accept the appointment. I will
(Name of person who will be member's representative)
act on behalf of the member to file a grievance, claim or appeal.

Relationship to Member: (Must be age 18 or older)	
Representative Signature:	Date:
Street Address:	Telephone (with area code):
City:	State: ZIP Code:

This authorization is good for one year from the date you sign this form unless you tell us the following:

Date: _____/_____/_____Or Event: _____
Month Day Year

Part 3 ---YOUR INDIVIDUAL RIGHTS (Please read):

I understand that:

- I do not have to sign this form.
- I can cancel this form by writing to AlohaCare at the address below except for the information that was already disclosed.
- Once my protected health information is disclosed to the person or organization I specified in **Part 1** of this form, the information in their possession may no longer be protected by privacy laws.

Please complete this form. Mail, fax, or deliver this form to the address below:

AlohaCare

1357 Kapiolani Boulevard, Suite 1250
Honolulu, HI 96814

Fax: 808-973-2140

Member Signature: _____ Date: _____

This document has important information from AlohaCare. You can request this document to be written in Ilocano, Vietnamese, Chinese (Traditional) and Korean. There is no charge. You can have it read to you. We also offer large print, braille, sign language and audio. Call us at 973-0712 or toll-free 1-877-973-0712. (TTY/TDD: 1-877-447-5990).

Tài liệu này có chứa thông tin quan trọng từ AlohaCare. Quý vị có thể yêu cầu tài liệu này được viết bằng tiếng Ilocano, tiếng Việt, tiếng Trung (Phồn thể) và tiếng Hàn. Dịch vụ này là miễn phí. Quý vị có thể được đọc cho nghe. Chúng tôi cũng cung cấp bản in cỡ chữ lớn, chữ nổi, ngôn ngữ ký hiệu và âm thanh. Hãy gọi cho chúng tôi theo số 973-0712 hoặc số miễn phí 1-877-973-0712. (TTY/TDD: 1-877-447-5990).

Daytoy a dokumento ket naglaon dagiti napateg nga impormasyon manipud ti AlohaCare. Mabalin mo a dawaten a maisurat daytoy a dokumento iti Ilocano, Vietnamese, Chinese (Traditional) ken Korean. Awan ti bayad na. Mabalin da nga ibasa kenka. Maipaay mi met ti nakadadakkel a letra,naka-braille, mai-sign language ken audio. Umawag kadakami iti 973-0712 wenno iti libre a tawag iti 1-877-973-0712 (TTY/TDD) 1-877-447-5990

본 문서에는 AlohaCare의 중요한 정보가 들어 있습니다. 본 문서는 일로카노어, 베트남어, 중국어(번체) 및 한국어로 번역되어 있습니다. 본 문서는 무료입니다. 귀하에게 읽어 주도록 요청할 수도 있습니다. 또한 큰 활자체, 점자, 수화 및 오디오도 제공해 드립니다. 937-0712 또는 수신자 부담 무료 전화 1-877-973-0712로 전화주십시오. (TTY/TDD: 1-877-447-5990).

本文件內含來自AlohaCare
的重要訊息。您可要求本文件的伊洛卡諾文、越南文、繁體中文和韓文等書面版本。免費提供。您也可要求閱讀服務。我們亦提供大字體、點字版、手語和語音服務。請致電973-0712或免費電話1-877-973-0712。（聽障／語障專線：1-877-447-5990）。