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 [Health Plan] 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: _____

[Language Block]