## Authorized Representative Form

You have the right to choose someone to represent you regarding your Appeal or Grievance with California Health & Wellness. To appoint a person to represent you, please fill out this form and return it to California Health & Wellness. If you want someone to represent you and we do not get a signed Authorized Representative Form in time to resolve your Appeal, your Appeal may be dismissed. If any such action is taken, we will let you know in writing.

You may cancel this permission at any time by sending us a request in writing.

1. I give permission to _____ to act as my Authorized
   *Name of Authorized Representative*
   Representative to California Health & Wellness and to share information listed in Section 2 about my Appeal or Grievance with California Health & Wellness or its delegate.
2. California Health & Wellness may share the following information (check all that apply):
   - ☐ Eligibility notices and information about eligibility for and access to my California Health & Wellness benefits
   - ☐ Information about my medical treatment (including drug and alcohol treatment, medical and psychiatric records)
   - ☐ Other: _____
3. California Health & Wellness may share information listed in Section 2 above with the person who is serving as my Authorized Representative.
4. This permission is good until: _____ / _____ / _____
   Month Date Year
5. I understand that I can cancel this permission at any time by sending a letter to: California Health & Wellness, 1740 Creekside Oaks Drive, Suite 200, Sacramento, CA 95833 or faxing a letter to:1-855-460-1009.

**I have read and understand this Authorization. I agree to its terms.**

Sign Here ➢ _____ _____

Signature of Member or Authorized Representative Date

_____

Print Name of Member or Authorized Representative

**DIRECTIONS:** Please fax this form to: **1-855-460-1009** or mail it to: California Health & Wellness, Attn: Appeals and Grievance Coordinator, 1740 Creekside Oaks Drive, Suite 200, Sacramento, CA 95833.