McLaren HEALTH PLAN | McLaren HEALTH PLAN COMMUNITY | McLaren HEALTH ADVANTAGE

AUTHORIZED REPRESENTATIVE FORM FOR GRIEVANCE/APPEAL

Claim# (if applicable): _____ and/or Date of Service: _____

Section A: Member Information

By signing this form (**Section E**), I understand and agree that McLaren Health Plan (MHP), McLaren Health Plan Community (MHP Community) and/or Health Advantage (MHA) may release my personal health information as defined (**Section B),** to my Authorized Representative named in **Section C**, and that such Authorized Representative is authorized **to file a Grievance/Appeal** *on my behalf*, thereby exhausting my right to file such a Grievance/Appeal.

All information in the form must be completely filled out.

Member Name: _____

Address: _____

Telephone Number: _____ ID#: _____

Please Note: This authorization does not provide your Authorized Representative with any authority, either implied or direct, in regard to any treatment or direct care decisions.

Section B: Type of Information

Describe the specific health information you are authorizing to be used or disclosed:

_____

_____

Section C: Authorized Use and/or Disclosure

Intended Use or Disclosure:

I understand that the general policy of MHP/MHP Community/MHA is to not disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize MHP/MHP Community/MHA to discuss and disclose my personal health information to the person named below for the purpose of assisting with, or filing, a Grievance/Appeal on my behalf. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my Authorized Representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

Authorized Representative Information (Parent, Spouse, Doctor, Facility, or other Authorized Representative):

Name: _____ Phone #: _____

Address: _____

Relationship to Member: _____

Section D: Expiration and Revocation

This authorization to release information to my Authorized Representative will automatically expire upon completion of the Grievance/Appeal filed on my behalf.

I understand that I have the right to revoke this authorization at any time. I understand that, if I do not wish the person named in **Section C** to remain my Authorized Representative, I must revoke this authorization by giving written notice of my decision to MHP, MHP Community, or MHA Grievance/Appeals at the address listed below. I understand that my revocation of this authorization will not affect any action that MHP, MHP Community or MHA has taken, or any information that MHP, MHP Community or HA may have already released, based upon this authorization before MHP/MHP Community/MHA actually received my request to revoke it.

MHP, MHP Community or MHA Grievance/Appeals
P. O. Box 1511
Flint, MI 48501-1511

Section E: Signature

I have read this Authorized Representative Form. I understand that by signing this form, I am confirming my authorization that MHP, MHP Community or MHA may use and/or disclose my personal health information to the person(s) named in **Section C** for the purpose described above.

Signature:
Please print name: Date:

PLEASE RETURN THIS SIGNED AUTHORIZATION FORM TO:

Email: MHPAppeals@mclaren.org
Fax: 810-600-7984
Mail to: McLaren Health Plan, McLaren Health Plan Community or McLaren Health Advantage Attn: Appeals Department
G-3245 Beecher Road
Flint, MI 48532