UnitedHealthcare" Designation of Authorized Representative

Member Name *(please print)*	Date of Birth	Member ID number	
Member's Street Address	City	State	Phone
Name of Individual/Company/Law Firm being designated as the authorized representative			
Bruno Brown Plastic Surgery			
Designated Representative's Address	City	State	Phone
Provider of Service			
Date(s) of Service or Proposed Service			

L_____ doherebynmne

Print the name of the member who is receiving the service or supply

Bruno Brown Plastic Surgery; Howard Healthcare Group and/or their attorneys.

_____

Print the name of the person who is bdng authorized to act on the member's behalf

to act as my authorized representative in requesting (*check all that apply)*

a complaint an appeal documents

from UnitedHealthcare regarding the above-noted service or proposed service.

I understand and agree that:

- This authorization is voluntary;
- my health information may contain infom1ation created by other persons or entities including health care providers and may contain medical, pham1acy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information:
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits ifl do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal _priv::i v re gnlatiM;
- this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying UnitedHealthcare in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Signature of Member	Date
If person signing this authorization is not the member, describe relationship to the Member(i.e. Parent, Legal Representative)	

Legal Representatives signing this authorization on behalf of a member must furnish a copy of a health care power of attorney, or other relevant document that grants the applicable legal authority