

**COLLEGE OF THE SISKIYOU'S HEALTH PLAN
DESIGNATION OF AUTHORIZED REPRESENTATIVE**

I _____, do hereby appoint _____ (hereinafter "my Authorized Representative") to act on my behalf in pursuing a benefit claim, specifically, *Description of Claim for Health Benefits, for example, claim relating to treatment of injury sustained on specific date or treatment rendered on specific date* _____ (the "Claim"). My Authorized Representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the Claim, any requests for documents relating to the Claim, and any appeal of an adverse determination of the Claim.

I understand that in the absence of a contrary direction from me, College of the Siskiyou's Health Plan (the "Plan") will direct all information and notices regarding the Claim to which I otherwise am entitled, including benefit determinations, to my Authorized Representative **only**.

I am aware that the Standards for Privacy of Individually Identifiable Health Information set forth by the U.S. Department of Health and Human Services (the "Privacy Standards"), govern access to medical information. I understand that in connection with the performance of his/her duties hereunder, my Authorized Representative may receive my Protected Health Information, as defined in the Privacy Standards, relating to the Claim. I hereby consent to any disclosure of my Protected Health Information to my Authorized Representative.

Date: _____

SIGNATURE OF CLAIMANT

ACKNOWLEDGMENT

I, _____, have read the above Designation of Authorized Representative and I hereby accept this designation and agree to act as Authorized Representative for _____ with respect to the Claim defined above.

DATE: _____

SIGNATURE OF REPRESENTATIVE

Notices may be sent to the Authorized Representative at the following address:

Representative Address #1 _____