AUTHORIZED REPRESENTATIVE FORM FOR GRIEVANCE AND APPEALS

If you choose to have a person be your representative to communicate with Valley Health Plan (VHP) on your behalf, complete section 1-3 below. Your personal representative may file a grievance or appeal on my behalf, and may use, receive, disclose your Protected Health Information.

Section 1 – Appointment of Representative
To be completed by the Member or Minor's parent/guardian.

Name of Member:____________________

Member ID:____________________ Date of Birth:____________________

Telephone Number:____________________

Address:____________________

Name of Minor's parent/guardian:____________________

Signature of Member or Minor's parent/guardian:____________________

Date:____________________

Section 2 – Authorized Use and/or Disclosure
☐ **Check this box to acknowledge that you have read each condition.**

- I authorize the representative to make any request, file and obtain appeals and grievances information, receive any notice in connection with my appeal or health care services in my place.
- I acknowledge that my authorization is voluntary. I understand that I may revoke this appointment at any time by giving written notice to VHP Member Services, 2480 N. First Street Suite 160, San Jose, CA 95131. I understand that the source of medical information about me may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization form. I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal privacy regulations. I understand I have a right to receive a copy of this authorization.
- I authorize VHP to release any of my medical records from the period (enter Month/Day/Year) ____________ to ____________ (**If no time period is provided, all records will be made available to the representative)** my appointed representative in order for her or him to act on my behalf and/or my child's behalf in filing a grievance and/or appeal.

This representative designation expires on (enter Month/Day/Year) ____________________
(If no expiration date is provided, this appointment is in effect until revoked in writing).

Section 3 – Acceptance of Appointment

To be completed by the representative(s).

I (We) hereby accept the above appointment.

Name of Authorized Representative #1: ______________________________

Name of Organization (if applicable): ______________________________

Relationship/Professional Status: ______________________________

Telephone Number: ______________________

Address: ____

☐My power of attorney for health care decisions or other legal document is attached (check if applicable)

Signature of Authorized Representative #1: __________________________

Date: _________________________

Name of Authorized Representative #2: ______________________________

Name of Organization (if applicable): ______________________________

Relationship/Professional Status: ______________________________

Telephone Number: ______________________

Address: ____

☐My power of attorney for health care decisions or other legal document is attached (check if applicable)

Signature of Authorized Representative #2: __________________________

Date: _________________________

If you have any questions, please call Member Services at **1-888-421-8444**.
For TTY/TDD users, utilize **711** or send email to **MemberServices@vhp.sccgov.org**.
Please mail or fax the completed form to

Attn: Member Services,
Valley Health Plan
2480 N. First Street Suite 160
San Jose, CA 95131
Fax: 1-408-885-4425.