Appointment of Authorized Representative (AOR) Form

As a member of Alameda Alliance for Health (Alliance), you have the right to authorize (give) a friend, family member, or another person you identify access to certain medical information about you.

To exercise this member right, you must **complete all fields** of this form and mail, fax, or email it to:

Alameda Alliance for Health
ATTN: Member Services Department
1240 South Loop Road
Alameda, CA 94502
Fax: **1.877.747.4504**
Email: **memberservices@alamedaalliance.org**

Part A: Tell us about you

Alliance Member:

Last Name: _____ First Name: _____

Phone Number: _____ Alliance Member ID #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Part B: Tell us about your representative

Name of Authorized Representative:

Last Name: _____ First Name: _____

Phone Number: _____ Relationship to Member: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Part C: My representative can do the following

This appointment allows my authorized representative to act on my behalf for the following Alliance services:

- Change my doctor/medical group
- File a grievance or appeal
- Order a new Alliance member ID card
- Speak to the Alliance on my behalf to assist in the coordination of my medical care

Part D: Read and sign

AUTHORIZED REPRESENTATIVE ACCEPTANCE

I have read this form and understand that:

- The Alliance Member may revoke this appointment at any time and appoint another individual(s) to act as their authorized representative.
- I have no other power to act on the Member's behalf, except for the Alliance services as stated above in Part C.
- I may not transfer or reassign my appointment.
- I may stop (revoke) this appointment at any time by sending a written request to Alliance.
- I agree to obey all state and federal laws governing authorized representatives. Including, but not limited to, laws about the privacy of information, rules against reassigning provider claims, and conflicts of interest.

By signing below, I hereby accept this appointment:

Authorized Representative's Signature: _____ Date: _____

PURPOSE & MEMBER RIGHTS

I have read this form and understand that:

- By filling out this appointment, I agree to have my authorized representative act on my behalf for the services selected above in Part C.
- My rights and responsibilities as a member of the Alliance do not change because I have an authorized representative.
- I understand that once the information is disclosed pursuant to this authorization, it might be re-disclosed by the recipient and the information may not be protected by federal or state privacy regulations.
- I am aware that I may stop (revoke) this appointment at any time by sending a written request to the Alliance at:

  Alameda Alliance for Health
  ATTN: Member Services Department
  1240 South Loop Road
  Alameda, CA 94502
  Fax: **1.877.747.4504**

By signing below, I hereby authorize this appointment, effective on the date of signing:

Signature: _____ Date: _____

Relationship if signing on behalf of the member: _____

If signing on behalf of the member, you must provide documentation that authorizes you to be the member's personal representative along with this form. (For example, a Health Care Power of Attorney, Letters of Conservatorship etc.)