Authorized Representative (AOR) Form and Authorization for Release of Protected Health Information

As a member of Alameda Alliance for Health (Alliance), you can choose to have a person be your authorized representative (AOR). Your AOR can communicate with us on your behalf. We will work with this person just as we would with you. Your AOR may act for you in most health care matters, and receive and disclose your Personal Health Information (PHI). Please complete this form to request an AOR.

INSTRUCTIONS

1. Please print clearly, or type in the fields below.
2. Please return the completed form by mail or fax:
   Alameda Alliance for Health
   ATTN: Member Services Department
   1240 South Loop Road
   Alameda, CA 94502
   Fax: **1.877.747.4504**

SECTION 1: MEMBER INFORMATION *(REQUIRED)*

ALLIANCE MEMBER:

LAST NAME: _____ FIRST NAME: _____

ALLIANCE MEMBER PARENT/GUARDIAN *(IF APPLICABLE)*

LAST NAME: _____ FIRST NAME: _____

ALLIANCE MEMBER ID #: _____ DATE OF BIRTH (MM/DD/YYYY): _____

HOME PHONE NUMBER: _____ CELL PHONE NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SIGNATURE: _____ DATE: _____

THIS FORM CONTINUES ON THE NEXT PAGE.

SECTION 2: TYPE OF MEMBER INFORMATION AUTHORIZED *(REQUIRED)*

☐ I authorize the use and disclosure of any PHI, which includes my treating providers, diagnoses, procedures, demographic information, claims for coverage or benefits, and receipt of any approvals or authorizations required for medical services. **This also includes mental health, drug or alcohol abuse, and HIV/AIDS-related information, unless otherwise excluded below:**

- ☐ Exclude HIV/AIDS-related information
- ☐ Exclude Mental Health information
- ☐ Exclude Drug or alcohol abuse information
- ☐ Exclude other: _____

Please Note: This authorization does not give the representative authority over treatment or direct-care decisions. Nor does it alter how the Alliance processes your health care services.

SECTION 3: AUTHORIZED USE AND/OR DISCLOSURE *(REQUIRED)*

Please select each box to acknowledge that you have read and understood each condition.

☐ I appoint the person below to act as a representative for me and/or my child.
☐ I authorize the representative to receive, discuss, and disclose PHI.
☐ I acknowledge that my authorization is voluntary.
☐ I understand that I may cancel it at any time by giving written notice to the Alliance.
☐ This appointment is effective immediately and will remain in effect for **one (1) year** from the date of signature, or as indicated here: _____ *(ending date)*.

SECTION 4: AUTHORIZED REPRESENTATIVE INFORMATION AND ACCEPTANCE OF APPOINTMENT *(REQUIRED)*

By completing this form, I accept the above appointment.

NAME OF AUTHORIZED REPRESENTATIVE: _____

NAME OF ORGANIZATION *(IF APPLICABLE)*: _____

HOME PHONE NUMBER: _____ CELL PHONE NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SIGNATURE: _____ DATE: _____

ALAMEDA Alliance FOR HEALTH

Questions? Please call the Alliance Member Services Department
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**
www.alamedaalliance.org