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			
Lake Washington Anesthesia			
Designated Representative's Address	City	State	Phone
PO Box 865539	Orlando	FL	206-458-7495
Provider of Service			
Date(s) of Service or Proposed Service			

I, _____, do hereby name
Print the name of the member who is receiving the service or supply
Stephanie Stuart
Print the name of the person who is being authorized to act on the member's behalf
to act as my authorized representative in requesting (*check all that apply*)

X a complaint X an appeal X 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 information created by other persons or entities including health care providers and may contain medical, pharmacy, 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 if I 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 privacy regulation;
- 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