CLEAR FORM

Appointment of Representative

Customer Name *(print)*	Date of Birth	Customer ID Number
Customer's Street Address	City	State and Zip Code
Healthcare provider	Date of Service	

I, _____ , choose
(Print your name.)

_____
(Print the name and address of the person or entity allowed to act on your behalf.)

to be my Authorized Representative for the service noted above. That means they can act on my behalf for:

(Check all that apply.)

- ☐ Complaints
- ☐ Appeals
- ☐ Receiving and responding to information from Cigna Healthcare about:
  - this service
  - and/or requests for equipment or supplies

I understand and agree that:

- I freely chose this person or entity to represent me.
- My health information:
  - may be shared with or by my Authorized Representative.
  - may include information created by others, such as health care providers and facilities.
  - may contain medical, pharmacy, dental, vision, mental health, alcohol/substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease, and health care program details.
- If I don't sign this form, I will still get the medical help I need. It won't stop my treatments, payments for health care services, or enrollment or eligibility for health care benefits.
- If I don't sign this form, Cigna Healthcare won't be able to process the complaint, appeal or document request sent in by my Authorized Representative.
- My Authorized Representative may share my health information with others. If those receiving it are not health plans or providers, my information may no longer be protected by federal privacy laws.
- This approval ends 2 years from the date I sign this form, unless state laws set a shorter time-period. I may end this approval at any time by letting Cigna Healthcare know in writing.

Signature of customer *(or authorized representative)* **Date:**

If the person signing this form is not the customer, explain who they are in relation to the customer (such as a parent or legal representative).

CLICK TO PRINT