Authorized Representative Form

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 act for you in most health care matters, and may use, receive, disclose your Protected Health Information.

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 return the completed form to **Attn: Member Services, Valley Health Plan, 2480 N. First Street Suite 160, San Jose, CA 95131**, or fax it to **1-408-885-4425**.

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 each 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, wholly in my stead.

☐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.

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

☐I authorize VHP/DMHC to release any of my Personal Health Information and/or Identifiable Health Information to my appointed representative in order for her or him to act on my behalf and/or my child's behalf

Or

☐This authorization is limited to: _____

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: _____