**AGENCY FOR HEALTH CARE ADMINISTRATION**

**Subscriber Assistance Program**
**2727 Mahan Drive, Mail Stop 26**
**Tallahassee, FL 32308**
**FAX: (850) 413-0900**

## APPOINTMENT OF REPRESENTATION

_____

SUBSCRIBER'S NAME (please print)

_____

REPRESENTATIVE'S NAME (please print)

_____(_____)_____

REPRESENTATIVE'S MAILING ADDRESS PHONE #

## APPOINTMENT OF REPRESENTATIVE

I appoint the above named individual to act as my representative in connection with my grievance against

_____ filed with the Subscriber Assistance Program (SAP).
(MANAGED HEALTH CARE PLAN)

**I authorize this individual to furnish any information requested by the Agency for Health Care Administration (Agency) and/or the SAP, to communicate with the Agency and SAP on my behalf, to receive notices of any hearing and to appear on my behalf at a hearing on my grievance against the managed care entity. I further authorize release of my medical records to my appointed representative, the SAP, the Agency, the Department of Financial Services (Department), the Office of Insurance Regulation (Office), and any medical expert whom the Agency, the SAP, the Department, and/or the Office may consult, deemed necessary by the Agency and to receive any notice in connection with my pending grievance or asserted right wholly in my stead.**

**Please indicate when you want this authorization to expire by choosing <u>one</u> of the following:**

**___ After the closure and compliance, when applicable, of my Subscriber Assistance Program case.**

**___ Specific date: _____**

**** If neither option is selected, authorization will automatically expire after the closure of your case. This authorization may be revoked at any time by notifying the Subscriber Assistance Program in writing.***

_____

**SUBSCRIBER'S SIGNATURE DATE**

_____

**REPRESENTATIVE'S SIGNATURE DATE**