SIGNATURE AND RELEASE OF MEDICAL RECORDS

To request a review of your health plan's adverse determination, you must sign and date this external review request form and consent to the release of medical records.

I, _____, hereby request an external review. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize my insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the Office for Consumer Health Assistance. I understand that the independent review organization and the Office for Consumer Health Assistance will use this information to make a determination on my external review and that the information will be kept confidential and not be released to anyone else. This authorization expires upon closure of OCHA case.

_____ _____
Signature of Covered Person or Legal Representative* Date

_____ _____
*Parent, Guardian, Conservator or Other (Please Specify) Date

Attach documentation of legal representation – Required Upon Submission

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this external review.)
You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my external review on my behalf.
First and Last Name

Signature of Covered Person (or legal representative)* _____
*Parent, Guardian, Conservator, or Other (please specify) _____

Address of Authorized Representative:
Street Name and Number
City: State: Zip Code:
Daytime Phone Number: Evening Phone Number: