

Authorized Representative Form

If you choose to have someone be your representative to communicate with Antidote Health on your behalf, complete sections 1-3. Your personal representative may act for you in most health care matters, and may use, receive, and/or disclose your Protected Health Information (PHI). If you have any questions, please email us at support@antidotehealth.com or call us at 1-888-623-3195 (TTY/RTT 711). For the latest Member Services hours and contact information, visit antidotehealth.com/contact.

Please fax the completed form to 1-888-396-8939 OR mail to
Attn: Member Services, Antidote Health Plan, PO Box 30002, Tampa, FL 33630

Section 1 - Appointment of Representative

To be completed by the Member or Minor's parent/guardian.

NAME OF MEMBER:	MEMBER ID:	DATE OF BIRTH:
ADDRESS:		TELEPHONE NUMBER:
NAME OF MINOR'S PARENT/GUARDIAN:	SIGNATURE OF 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 Attn: Member Services, Antidote Health Plan, PO Box 30002, Tampa, FL 33630 ☐ 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 Antidote Health Plan, Arizona Department of Insurance of Insurance and Financial Institutions or Ohio Department of Insurance to release any of my Personal Health Information and/or Identifiable Health Information to my appointed representative in order for them to act on my behalf and/or my child's behalf. ☐ This authorization is limited to:
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Section 3 - Acceptance of Appointment as Authorized Representative

To be completed by the representative(s).

NAME OF AUTHORIZED REPRESENTATIVE #1:	NAME OF ORGANIZATION (IF APPLICABLE):	RELATIONSHIP/PROFESSIONAL STATUS:
ADDRESS:		TELEPHONE NUMBER:
☐ 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:
ADDRESS:		TELEPHONE NUMBER:
☐ MY POWER OF ATTORNEY FOR HEALTH CARE DECISIONS OR OTHER LEGAL DOCUMENT IS ATTACHED (CHECK IF APPLICABLE)		
SIGNATURE OF AUTHORIZED REPRESENTATIVE #2:	DATE:	