Tarzana Outpatient Surgical Institute
5620 Wilbur Ave. Suite 305 Tarzana, CA 91356
818-578-5125

Member Name:_____ **Date:**_____

Member ID:_____

Member Authorization Form for the Designated Representative to Appeal a Determination

I hereby authorize Brand Tarzana Surgical Institute to appeal my insurance company's determination on my behalf, as my Designated Representative, and, as part of the appeal, concerning the services I received. I hereby authorize my insurance company in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain the following:

ALL MEDICAL AND FINANCIAL INFORMATION CONTAINED IN MY INSURANCE FILE, INCLUDING BUT NOT LIMITED TO TREATMENT FOR VENEREAL DISEASE, ALCOHOLISM AND DRUG ABUSE, ABORTION, MENTAL DISORDER AND HIV STATUS RELATING TO MY EXAMINTAION, TREATMENT AND HOSPITAL CONFINEMENT IN CONNCETION WITH THE DETERMINATION WHICH IS BEING APPEALED.

I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law. This authorization is valid for a period of one year.

_____

Signature of Member or Legal Guardian/Representative

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Signature of Designated Representative Name of Representative/Title