Illinois Department of Insurance

Appointment of Authorized Representative Form

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Revised 3/2020

This form is to be completed when someone other than the patient, parent, or guardian is representing the patient in this appeal. Health Care Providers must have this form completed in order to act as an Authorized Representative. This authorization may be revoked at any time with written notification to the Department of Insurance.

PATIENT INFORMATION

Last	First		MI
Address	**City**	**State**	**Zip**
Date of Birth	**Phone Number**	**Email**	

PERSON I AUTHORIZE TO PURSUE MY APPEAL (AUTHORIZED REPRESENTATIVE)

Relationship to Patient

Last	First		MI
Address	**City**	**State**	**Zip**
Phone Number	**Email**		
Organization Name (if applicable)	**Complaint Number (if applicable)**		

SIGNATURE FOR AUTHORIZATION

I authorize the above identified person to pursue this review on my behalf and to have access to my personal health information and financial information. I understand that my approval of this authorization is voluntary and that I may end my approval of this authorization, in writing, at any time.

By signing below I hereby authorize the release of medical records necessary for this review. I understand that these records may be obtained from the insurance carrier, the utilization review company, and/or any relevant medical provider(s) and will be utilized solely for the purpose of conducting this review and may be viewed by an auditor of the Department of Insurance for quality review and examination of record purposes.

I understand that information related ONLY to this review will be shared with the authorized individual.

Signature of Patient
(if under 18, signature of parent or guardian) _____ **Date**_____

Submit Form