Desert Perinatal ASSOCIATES

DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

Patient Name: _____ DOB: _____

An Authorized Representative is a person you authorize to act on your behalf, in the filing or pursuance of claims and the filing or pursuance of appeals of denied claims. This authorization is granted for any present or future claims for health care benefits you may have.

- I understand that as a result of authorization, my insurance company may disclose and release information concerning benefit eligibility, claims status, claims approval or claims denial reasons in connection with the above referenced health care claims to the individual names above.
- I understand my health information may include but not limited to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information.
- I understand that this authorization is voluntary.
- I understand this designation is subject to revocation at any time except to the extent that my insurance has taken action in reliance on this designation before they knew of the revocation.

By signing this form, you appoint Desert Perinatal Associates as your Authorized Representative.

_____ _____

Patient Signature Date

Southwest Location: 5761 S. Ft. Apache • Las Vegas, Nevada 89148
Summerlin Location: 10105 Banburry Cross, #430 • Las Vegas, Nevada 89144
Green Valley Location: 3001 Horizon Ridge Parkway • Henderson, Nevada 89052
Phone: (702) 341-6610 • Fax: (702) 341-6961 • www.DesertPerinatalAssociates.com