CHOICE PHYSICIANS NETWORK

HORIZON VALLEY MEDICAL GROUP

The Right Choice... To Better Your Health!

Member Authorization Form

I_____, appoint _____as my authorized representative to act on my behalf for the CPN/Horizon Valley Medical Group services described below.

MEMBER INFORMATION:

Member Name	Member ID	Date of Birth

AUTHORIZED REPRESENTATIVE:

Authorized Representative	Relationship to Member

Authorized Representative Address

AUTHORIZED SERVICES: (select any or all the following)

This appointment allows my Authorized Representative to act on my behalf for the following CPN/HVMG member services:

- ☐ Request my Protected Health Information
- ☐ Change my Primary Care Physician (PCP)
- ☐ Change my assigned IPA or Medical Group
- ☐ File a Grievance or Appeal
- ☐ Change my Member demographic information (address, phone number, etc.)
- ☐ Complete Health Risk Assessments or other Assessments to help my plan for care
- ☐ Other: _____

PURPOSE & MEMBER RIGHTS:

- By filling out this appointment, I agree to have my authorized representative act on my behalf for the CPN/HVMG member services selected above.
- CPN/HVMG and my authorized representative may only share the minimum necessary Protected Health Information (PHI) and other private facts to carry out CPN/HVMG services.
- I understand that I do not have to sign this Appointment and it is completely voluntary. My refusal will not affect my ability to obtain treatment, payment or eligibility for benefits. I understand that I have a right to receive a copy. I further understand that if the information provided by this Authorization is disclosed (given) to another person or agency, it may no longer be protected by federal confidentiality law (HIPAA). However, California law does not allow the person receiving the health information by this Authorization to disclose it, unless a new Authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I am aware that I may stop (revoke) this appointment at any time by sending a written request to CPN/HVMG at:

CPN/Horizon Valley Medical Group | Attn: Member Services

P.O. Box 2659| Apple Valley, CA 92307

Fax: (800) 887-5429| Email: Members@Choicemg.com

This Appointment is effective immediately and will remain in effect for one year from the date of signature, or as indicated here:_____(ending date).

AUTHORIZED REPRESENTATIVE ACCEPTANCE:

I have read this form and understand that:

- The CPN/HVMG Member may revoke this appointment at any time and appoint another individual(s) to act as their authorized representative;
- I have no other power to act on the Member's behalf, except for the CPN/HVMG services as stated above;
- I may not transfer or reassign my appointment.

I certify that:

- I have never been disqualified, suspended, or prohibited from practice before the Social Security Administration or the Department of Health and Human Services.
- I am not a current or former employee of the United States, disqualified from acting as the Member's authorized representative.

By signing below, I hereby accept this appointment:

Authorized Representative Signature	Date

MEMBER SIGNATURE:

By signing below, I hereby authorize this appointment:

Member Signature	Date

PLEASE COMPLETE ALL SECTIONS, SIGN, AND RETURN THIS FORM TO:

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P.O. Box 2659| Apple Valley, CA 92307
Fax: (800) 887-5429
Email: Members@Choicemg.com