

**COVENTRY HEALTH CARE OF NEBRASKA, INC.
AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION
TO APPEALS REPRESENTATIVE**

The following person will act on my behalf during appeals related to

_____ (please provide a brief description of the issue that will be appealed).

Name of person acting on my behalf: _____

Address of person acting on my behalf: _____

Telephone number of person acting on my behalf: _____

I understand that:

- I may revoke this authorization at any time by sending **Coventry Health Care of Nebraska, Inc.** written notification of my revocation;
- Revocation of this authorization will not affect any action **Coventry Health Care of Nebraska, Inc.** took in reliance on this authorization before it received my written revocation;
- This authorization will expire upon the completion of the appeals process;
- **Coventry Health Care of Nebraska, Inc. may need to provide my representative with my health information, which may include my protected health information (PHI), so that my authorized representative can participate in the appeals process.**

By signing below, I acknowledge that I have read and understand the information above.

Member Name: _____ (please print name) Date _____

Member signature: _____ Member ID Number: _____