County of Inyo
Health & Human Services Department
Behavioral Health

Authorized Representative Designation Form

Use this form to authorize someone who is not already legally authorized to act on your behalf during the grievance or appeal process.

MEMBER INFORMATION

Member Name:	Date of Birth:
Medi-Cal ID: (if known)	Email:
Mailing Address:	Phone:
Member's Preferred Method of Communication: ☐ Email ☐ Phone ☐ Mail ☐ Other	
Member Language Preference: ☐ English ☐ Spanish ☐ Other: _____ Do you need an Interpreter? ☐ Yes ☐ No	

REPRESENTATIVE INFORMATION

Name:	Relationship:
Address:	Phone:
Email:	Organization: (if applicable)
Representative Language Preference: ☐ English ☐ Spanish ☐ Other: _____ Do you need an Interpreter? ☐ Yes ☐ No	
Preferred Method of Communication: ☐ Email ☐ Phone ☐ Mail ☐ Other: _____	

AUTHORIZATION

I give my authorized representative authorization to receive and communicate for the following: (check all that apply)

☐ File Grievance ☐ File Appeals ☐ Receive Notices ☐ Discuss my confidential information

☐ Request records ☐ Represent me during State Fair Hearings ☐ All of the above

The authorization remains in effect until: (Check one)

☐ This grievance is resolved ☐ This appeal is resolved ☐ Revoked by me ☐ Date: _____

Date cannot be more than 1 year from the signed date of this form.

ACKNOWLEDGEMENTS

Member:	**Authorized Representative:**
By signing this form, I voluntarily authorize the individual identified on this form to act on my behalf during the grievance and/or appeal process with Inyo County Behavioral Health. I understand that this authorization permits Inyo County Behavioral Health to disclose only the information necessary to administer my grievance or appeal to my authorized representative. I understand that I may revoke this authorization at any time by providing written notice to Inyo County Behavioral Health. I also understand that revoking this authorization will not affect any actions taken before my written revocation is received. I acknowledge that my confidential information will be protected in accordance with applicable federal and state privacy laws. Member Signature: _____ Date: _____	By signing this form, I accept the responsibility to act on behalf of the member during the grievance and/or appeal process. I understand that any confidential information I receive is to be used solely for the purpose of representing the member in this matter and must be handled in a manner that protects the member's privacy. I acknowledge that I will act in accordance with the member's wishes, maintain the confidentiality of all protected information, and promptly notify Inyo County Behavioral Health if I am no longer authorized or willing to serve as the member's representative. Representative Signature: _____ Date: _____

To file this form:

You are required to sign this form to give the written consent. You can submit this form by mail or drop off at Health and Human Services Office or email it to inyobh@inyocounty.us or fax it to 760-873-3277.

- Bishop Office
  1360 N. Main Street, Bishop, CA 93514
- Lone Pine Office
  310 N. Jackson, Lone Pine, CA 93545

Free interpreter services, translated materials, and auxiliary aids are available upon request. If you need this form in another language or format, please contact Inyo County Behavioral Health.