



Appointment of Authorized Representative and Consent For Release of Medical Records

Illinois Department of Insurance

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

first name _____ last name _____

address _____

city _____ state _____ zip _____

daytime phone _____ email _____

Person I Authorize to Pursue My Appeal

first name _____ last name _____

address _____

city _____ state _____ zip _____

daytime phone _____ email _____

fax number _____

Signature for Authorization

By signing below I hereby authorize the release of medical records necessary for the external review. I understand that these records may be obtained from the Health Carrier, the Utilization Review Company, and/or any relevant medical provider(s) and will be utilized solely for the purpose of conducting this external review and may be viewed by an auditor of the Department of Insurance for quality review and examination of record purposes. I further authorize the above identified person to pursue an external review on my behalf and to have access to my personal health information and financial information.

signature of patient
(if under 18, signature of parent or guardian)

date

Return this form to:

Illinois Department of Insurance
Office of consumer Health Insurance
External Review Request
320 W. Washington Street
Springfield, IL 62767
877-850-4740 toll free phone
217-557-8495 fax
doi.externalreview@illinois.gov