Consumer Assistance Program
Department of Commerce
AUTHORIZED ASSISTANT FORM-English
New: 10/7/2013 Rev:

AUTHORIZED ASSISTANT FORM

- If you want to give another person the authority to assist you with your External Appeal or complaint, complete Parts A and B below. If you are a parent or legal guardian filing this appeal or complaint for a child under the age of 18, you do not need to complete this form.

- If you are filing this appeal or complaint for a patient who cannot complete this form because the patient is either incompetent or incapacitated, and you have legal authority to act for this patient, please complete Part B only. Also attach a copy of the power of attorney for health care decisions or other documents that say you can make decisions for the patient.

PART A: PATIENT

I allow the person named below in Part B to assist me in my appeal or complaint filed with the CNMI Consumer Assistance Program (CAP). I allow the CNMI CAP and staff of the external reviewer to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my denial appeal or complaint will be shared.
My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing.

Patient Signature ______________________________ Date ______________

PART B: PERSON ASSISTING PATIENT

Name of Person Assisting (print)

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Signature of Person Assisting____

Relationship to Patient ________________ Daytime Phone # ____________ Evening Phone #______

Address_______________________ City__________________ Zip Code _______________

My power of attorney for health care decisions or other legal document is attached.

For Office Use Only

Case #__________________________ABC___________.