



Designating a Client Representative

Mail the completed form to:
Colorado Access
PO Box 17950
Denver, CO 80217-0950

If you have questions or need
help completing this form,
please call us at (303) 751-9051
or toll free at 1-800-414-6198

Member _____

Authorized Representative _____

Relationship to Member _____

Address _____

Telephone _____

I hereby appoint the above person to serve as my Designated Client Representative for all purposes related to my grievance or appeal.

Signature of Member

Today's Date

I also give permission to Colorado Access to disclose any medical record and personal information related to my grievance or appeal that it possesses to my Designated Client Representative. This authorization begins on the date I sign it and remains in effect until my grievance or appeal is formally closed. I understand that I may cancel this authorization at any time by calling or writing Colorado Access. I also understand that if I do cancel my authorization, Colorado Access cannot take back any disclosures it has already made based on this authorization.

Signature of Member

Today's Date