



Appointment of Representative

I _____, have requested that Health Champion, LLC and specifically the individuals listed below represent me and/or my family member(s) in the following health care matter(s): general health advice, emergency room advocacy, including transition of care situations, health insurance issues or concerns, including reimbursement issues and filing appeals.

I do hereby swear that I am the above mentioned individual, or, an authorized representative of the above mentioned family member.

This authorization is effective _____ and remains in effect until for no longer than one year from date of this authorization. I may rescind this authorization at any time by notifying Health Champion LLC in writing.

Signature: _____ Date: _____

Name: First _____ /Last _____

If signed by a family member or a client representative –please complete the following:

Name: First _____ Last _____

Relationship: Spouse _____ Parent _____ Adult Child _____ Other _____

Do you have Durable Power of Attorney and/or Conservatorship: Yes _____ No _____

Copies of all appropriate documents checked above must be attached or faxed with form to be considered complete.

Signature: _____ Ida Schnipper, Health Champion LLC

Health Champion Authorized Representatives:

Ida Schnipper, RN Ellen Sue Moses, RPH Jay Salvio, RN

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