SAMARITAN HEALTH PLANS • INTERCOMMUNITY HEALTH PLANS • 2300 NW WALNUT BLVD • CORVALLIS OR 97330

AUTHORIZED REPRESENTATIVE

IDENTIFY YOUR PLAN:		
❑ Samaritan Advantage Health Plan ❑ Samaritan Choice Health Plan ❑ InterCommunity Health Network CCO ❑ Samaritan Employer Group Plan		
MEMBER INFORMATION: (Please print)		
Member's name:	Member ID:	Date submitted:
Address:	Telephone #:	
Email address:	Member DOB:	
AUTHORIZED REPRESENTATIVE #1: (Please print)		
Name:	Telephone #:	
Address:	Relationship to Member:	
AUTHORIZED REPRESENTATIVE #2: (Please print)		
Name:	Telephone #:	
Address:	Relationship to Member:	

I authorize Samaritan Health Plans (SHP) & InterCommunity Health Network CCO (IHN-CCO) to disclose the following information:

❑ Enrollment, eligibility, benefit information ❑ Medical Records and diagnosis ❑ Alcohol/substance abuse
❑ Preauthorization ❑ Claims, claim status, claim history ❑ Grievances
❑ Update/change PCP information or DCO information (applicable to SAHP & IHN-CCO)

EXPIRATION AND REVOCATION:

This authorization to release information to my Authorized Representative will automatically expire two years from the date of signature. I understand that I have the right to revoke or end this authorization at any time. I may cancel this authorization by sending written notice to SHP/IHN-CCO, P.O. Box 1310, Corvallis OR 97339. I understand that, if I do not wish the person(s) named to remain my Authorized Representative, I must revoke this authorization, in writing, by giving written notice of my decision to the health plan contact listed above. I understand that my revocation of this authorization will not affect any action that SHP/IHN-CCO has taken, or any information that SHP/IHN-CCO has already released, based upon this authorization before SHP/IHN-CCO actually receives my request to revoke it.

AUTHORIZED USE AND/OR DISCLOSURE

I understand that SHP/IHN-CCO's general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize SHP/IHN-CCO to discuss and disclose my personal health information to the person(s) named above for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, those privacy laws may no longer protect my personal health information, and my Authorized Representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

SIGNATURE/AUTHORIZATION:	
I have had full opportunity to read and consider the content of this Authorized Representative form. I confirm that this authorization is consistent with my request of the health plan and its administrator. I understand that, by signing this form, I am confirming my authorization that the health plan may use and/or disclose my personal health information to the person(s) named as Authorized Representative(s) for the purpose described above. *If the member cannot sign this form, a legal representative may sign, complete and return this form for the member. A legal representative is someone who has the legal right to sign for the member. Please attach proof that you are the member's legal representative (such as their Power of Attorney). We cannot accept this form without it.	
Signature:	Date:

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION FORM AFTER YOU SIGN IT.

Please fax or mail the completed and signed authorization form to:

Fax: (541) 768-9778

Mail:
SHP/IHN-CCO
PO Box 1310
Corvallis, OR 97339

Visit us:

Monday-Friday: 8am-5pm daily
SHP/IHN-CCO
2300 NW Walnut Boulevard
Corvallis, Oregon

If you have any questions about this form, please call Customer Service at 541-768-4550 or 1-800-832-4580, Monday - Friday, 8 a.m. to 8 p.m. TTY users should call 1-800-735-2900.