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

AUTHORIZED REPRESENTATIVE

IDENTIFY YOUR PLAN

❑ Samaritan Advantage Health Plan HMO ❑ Samaritan Choice Plans

❑ InterCommunity Health Network CCO ❑ Samaritan Employer Group Plans

MEMBER INFORMATION: (Please print)

Member Name:	Member ID:	Date Submitted:
Address:		Telephone:
Email:		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) and InterCommunity Health Plan (IHN) to disclose the following information:

❑ Employment, eligibility, benefit information ❑ Grievances ❑ Alcohol/substance abuse

❑ Preauthorization ❑ Claim information including diagnosis, claim status, claim history

❑ Update/change PCP information or DCO information (applicable to SAHP and IHN)

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, 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 has taken, or any information that SHP/IHN has already released, based upon this authorization before SHP/IHN actually receives my request to revoke it.

AUTHORIZED USE AND/OR DISCLOSURE:

I understand that SHP/IHN 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 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 the 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 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.

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.

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

Mail:
SHP/IHN
P.O. Box 1310
Corvallis, OR 97339

Visit us:
Monday – Friday: 8 a.m. – 5 p.m.
2300 NW Walnut Blvd.
Corvallis, Oregon

Fax: 541-768-9778