MEMBER REQUEST FOR HEALTH PLAN RECORDS

MEMBER'S HEALTH PLAN:

❑ IHN-CCO ❑ Samaritan Advantage ❑ Samaritan Choice ❑ Samaritan Employer Group Plans

MEMBER INFORMATION:

Last name:	First name:	MI:

Phone:	Date of Birth:_____ / _____ / _____	Health Plan ID #:

Address:

REQUEST:

I request copies of the following health plan records. By placing my initials next to any of the items below, I am specifically requesting the release of the selected item(s), if such record exists (initial all items that apply):

_____ Call history _____ Claims data ______ Prior authorization and/or chart notes

_____ Eligibility data _____ Appeal and/or grievance documentations

_____ Other (please describe): ____

List date(s) of service or describe what this request is connected to:

Please include the following types of medical information with this request (check all that apply):

❑ HIV/AIDS ❑ Genetic testing ❑ Drug/alcohol diagnosis, treatment or referral
❑ Mental health ❑ Sexually transmitted disease

SIGNATURE:

I understand that this is a **one-time** request for my health plan records. I will receive the records no later than 30 days from the date requested. I understand that I have the right to access my health plan records. Signing this form will not affect my health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

Signature:____ Date: ____________________

If you are the Authorized Representative, you must sign above and provide the following information:

Name: ____ Phone: ____________________

Address: ______________________________ Relationship to Enrollee: ____________________

FAX completed form to (541) 768-6701
MAIL to SHPO/IHP, Attn: Customer Service, PO Box 1310, Corvallis, OR 97339

SHPO/IHP USE ONLY: Completed date: ________________________ Staff initials: ______________
Operations Manager initials:________________________________