

Interoperability allow/revoke authorized representative's access

A member of Samaritan Health Plans (SHP)/InterCommunity Health Network Coordinated Care Organization (IHN-CCO), or their authorized representative, may allow or revoke their authorized representative's access to their data in a third-party application (app).

Please ensure the form is completed and signed before submitting it. Missing information may result in your request being canceled. If canceled, a new, completed form must be submitted.

Member information:

Last name: _____ First name: _____ MI: _____

Address: _____

City: _____ State: _____ ZIP: _____

Date of birth (MM/DD/YYYY): _____ Member ID: _____

Email: _____

Note: Follow-up communications regarding this request will be conducted only by email. If you do not provide an email address, this form will not be processed.

Member's authorized representative information (if applicable):

For interoperability data sharing requested by an authorized representative, SHP/IHN-CCO must have a documented authorized representative relationship on file. This form does not create an authorized representative relationship.

Last name: _____ First name: _____ MI: _____

Email: _____

Note: Follow-up communications regarding this request will be conducted only by email. If you do not provide an email address, this form will not be processed.

Request details:

To allow access to a member's data in a third-party app by an authorized representative, SHP/IHN-CCO requires documentation of an existing representation relationship such as a medical power of attorney. This form does not create an authorized representative relationship.

Allow Revoke Last name: _____ First name: _____

Third-party app name (example: iHealth): _____

Third-party app developer name (example: Apple): _____

Note: Submission of this form will allow or revoke access only for the app listed above. A separate form must be submitted for each third-party app that you want to allow or revoke access to.

SHP/IHN-CCO understands that your protected health information is personal, and is committed to protecting your privacy. SHP/IHN-CCO is obtaining this written authorization before information is disclosed for the reasons listed below.

To understand your privacy rights, please visit SHP and IHN-CCO privacy at samhealthplans.org/Notice-Of-Privacy-Practices.

Member rights:

I understand that my protected health information may be accessed, exchanged, or used by an electronic health information exchange (EHIE) application (or covered entity/other payers).

I understand I have the right to adequate notice of how the EHIE will use my protected health information. I understand I have the right to refuse or opt-out of this authorization at any time.

I understand that refusal to sign the authorization will generally not negatively affect my ability to receive health care services or reimbursement for services. I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal law. This authorization may be canceled (revoked) at any time.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

You can find more information about interoperability at samhealthplans.org/ThirdPartyApps and IHN-CCO's education page at IHNtogether.org/ThirdPartyApps.

Please initial indicating that you have read the "Member rights" section of this form.

Initial here: _____

A handwritten signature is required on this form. Electronic signatures are not accepted.

Who is making this request? Member Member's authorized representative

Requester signature: _____ Date: _____

Requester printed name: _____

Choose a form submission option:

- **Email** completed and signed form to HealthPlanResponse@samhealth.org.
- **Mail** completed and signed form to Samaritan Health Plans/IHN-CCO, Attn: Customer Service, PO Box 1310, Corvallis, OR 97339.

If you have questions about this form, please call Customer Service at **541-768-4550** or **800-832-4580** (TTY **800-735-2900**), Monday through Friday from 8 a.m. to 8 p.m.