Interoperability payer data exchange

A member, or their authorized representative, must complete this form to request Samaritan Health Plans (SHP)/InterCommunity Health Network Coordinated Care Organization (IHN-CCO) to share the member's health information with another payer.

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 about 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 requests 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 about this request will be conducted only by email. If you do not provide an email address, this form will not be processed.

Payer information:

Allow electronic data exchange of the member's health information to the following payer:

Payer name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Email (if available): _____

Payer website (if available): _____

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 your information may be disclosed for the reasons listed below.

You can find the SHP and IHN-CCO Notice of Privacy Practices 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 application (EHIE) (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 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** or **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.