SHP/IHN-CCO Record Request Form

Member information:

First name: _____ Middle initial: _____ Last name: _____

Address: _____ Date of birth: _____

City: _____ State: _____ ZIP: _____

Email: _____ Phone: _____

Health information to be released from (please check all that apply):

☐ Samaritan Advantage Health Plans
☐ Samaritan Employer Group Plans
☐ Samaritan Choice Plans
☐ InterCommunity Health Network CCO

What is the purpose of this request?

☐ Continuing care ☐ Personal ☐ Legal ☐ Other (specify):
☐ Insurance ☐ School ☐ Disability _____

What information do you want shared?

☐ Case management notes ☐ Claims information ☐ Other (specify):
☐ Prior authorization ☐ Appeal and/or grievance information _____
☐ Eligibility data

Date range of information: ☐ From _____ to _____ ☐ All dates

This authorization will automatically expire 12 months from date of signature (unless another date, event or no expiration is specified here): ☐ On this date: _____

☐ After the following event (please describe): _____

Initial below to share the following protected information:

_____ Mental health records, including psychotherapy notes.
_____ HIV test results, diagnosis or treatment information.
_____ Genetic testing information or records.
_____ Alcohol or substance use disorder records (see page 2 for additional information).

If initialed, please describe the information you wish to share, and how much information to share with your designated recipient:

_____

Who do you want to receive your information?

Please share my records with: ☐ Myself at the contact information above ☐ The person or entity listed below

Name: _____ Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ ZIP: _____

Please send my information via:

☐ Mail (paper) ☐ Email ☐ Other (specify): _____

My rights:

I can refuse to sign this authorization. My refusal to sign this authorization will not negatively impact my ability to receive health care services, or otherwise affect my eligibility for or continued enrollment in an insurance plan. I understand that the information disclosed as a result of signing this form may be redisclosed by the recipient and no longer protected under federal or state privacy laws. I may be charged a fee in certain circumstances for copies of the records I request. If applicable, these fees are described under the Additional Information section below. I can cancel or revoke this authorization at any time, in writing, by notifying Customer Service at PO Box 1310, Corvallis, OR 97339.

The member's signature is required. If the member is a minor under the age of 18 or is an adult who is incapable of signing the authorization, a legally authorized personal representative may be able to sign on the member's behalf. See the Additional Information section below for additional guidance.

Member signature: _____ Date: _____

Personal representative signature:
(if signing on behalf of member) _____ Date: _____

Representative name (please print): _____ Relationship to member: _____

Fax completed form to 541-768-6701
or mail completed form to Samaritan Health Plans/InterCommunity Health Network CCO,
Attn: Customer Service, PO Box 1310, Corvallis, OR 97339

Additional information:

Fees:

- Member for paper copies: no charge.
- Continuing care: no charge.
- Third party requests: reasonable cost-based fee may apply in accordance with HIPAA and Oregon law.

Notice to recipient regarding records protected under 42 CFR 2:
Alcohol or substance use disorder records are protected under federal regulations known as 42 CFR 2. If disclosure of these records has been authorized by the member, please note that 42 CFR 2 prohibits the unauthorized redisclosure of these records.

Minors:

- If the member is 17 years of age or younger, the member's parent or legal guardian must sign and date the form. Please provide your relationship to the member. If you are the member's legal guardian, please include supporting documentation.
- In Oregon, minors may be able to request certain levels of confidentiality or consent to various health care matters on their own, depending upon their age. It is SHP policy to require the minor to authorize disclosure of any records or information pertaining to these services.

Adults unable to sign for themselves due to disease or condition:

- A legally authorized personal representative may sign and date the form on behalf of the member in certain circumstances. If signing on behalf of an adult member, please indicate your relationship to the member (e.g. guardian, health care representative, power of attorney for health care) and include supporting documentation of your relationship.

Questions?

If you have questions about this form, please call Customer Service at **541-768-4550** or **800-832-4580** (TTY **800-735-2900**).

Samaritan Advantage Health Plans

- Oct. 1 to March 31: Daily from 8 a.m. to 8 p.m.
- April 1 to Sept. 30: Monday through Friday from 8 a.m. to 8 p.m.

All other Samaritan Health Plans and InterCommunity Health Network CCO

- Monday through Friday from 8 a.m. to 8 p.m.