

## AUTHORIZED REPRESENTATIVE FORM

**Note:** This form is used to confirm permission for the health plan to discuss or disclose a subscriber’s protected health information to a particular person who acts as the subscriber’s Authorized Representative. Use of this information is strictly limited to that purpose described herein.

**This document is available in alternate formats for persons with special needs. Please call 1-800-832-4580 to request this service. TTY users should call 1-800-735-2900.**

### REQUESTOR’S INFORMATION

By signing this form, I understand and agree that Samaritan Health Plan Operations (SHPO) may release my personal health information, defined as, but not limited to, identification of treating providers of care, personal diagnoses, procedures and demographic information (but not including any psychotherapy notes). I understand that this authorization does not provide my Authorized Representative with any authority, either implied or direct, over any treatment or direct-care decisions. I also understand that executing this form will not alter the manner in which SHPO processes my benefits payments, enrollment/change forms or my eligibility for benefits.

<b>SELECT YOUR PLAN:</b>				
<input type="checkbox"/> Samaritan Advantage	<input type="checkbox"/> Samaritan Choice	<input type="checkbox"/> COHO	<input type="checkbox"/> IHN	<input type="checkbox"/> Samaritan Healthy KidsConnect
<b>REQUESTOR’S INFORMATION:</b>				
Requestor’s name:		Date Submitted:	SSN #:	
Address:			Telephone #:	
Member name:			Member ID:	
Email Address:			Member SSN#	

### AUTHORIZED USE AND/OR DISCLOSURE

#### Intended Use or Disclosure:

I understand that SHPO’s 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 SHPO to discuss and disclose my personal health information to the person(s) named below 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.

<b>AUTHORIZED REPRESENTATIVE #1:</b>	
Name:	Telephone #:
Address:	Relationship:

<b>AUTHORIZED REPRESENTATIVE #2:</b>	
Name:	Telephone #:
Address:	Relationship:

I understand that I have the right to limit the information that SHPO releases under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. **Any such limitations must be described below in writing.**

**I understand that by leaving this section blank, I am creating no limitations on disclosure.**  
**LIMITATIONS ON DISCLOSURE:**

**EXPIRATION AND REVOCATION**

This authorization to release information to my Authorized Representative will automatically expire two years following the termination of my health plan enrollment. I understand that I have the right to revoke or end this authorization at any time. 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 below. I understand that my revocation of this authorization will not affect any action that SHPO has taken, or any information that SHPO has already released, based upon this authorization before SHPO actually receives my request to revoke it.

**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.

<b>SIGN HERE:</b>	
Signature:	Date:

**YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION FORM AFTER YOU SIGN IT.**

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

<b>Fax:</b>	<b>Mail:</b>	<b>Visit us:</b>
(541) 768-6701	Samaritan Health Plan Operations PO Box M Corvallis, OR 97339	Samaritan Health Plan Operations 815 NW Ninth Street, Suite 101 Corvallis, Oregon

If you have questions about this form, please call Customer Service at 1-800-832-4580, Monday–Friday, 8 a.m. to 5 p.m. TTY users should call 1-800-735-2900.