Authorization for Verbal Communication

This authorization is limited to verbal discussion about your plan benefits, care management and/or payment for care only. No paper copies of your health plan record will be provided using this authorization. If you have any 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.

Identify your plan:

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

Member information:

Member name:	Member ID:
Address:	Phone:
Email:	Date of birth:

Information that can be discussed:

I authorize Samaritan Health Plans (SHP) and/or InterCommunity Health Network CCO (IHN-CCO) to verbally discuss my health care or payment for my health care with the people listed below:

I do not want the following information shared (if left unmarked, information can be shared):

☐ HIV diagnosis, testing or treatment information.
☐ Genetic testing information.
☐ Mental health information.
☐ Alcohol or substance use disorder information.
☐ Other (please specify): _____

Information can be discussed with the following people:

Name:	Phone:
Address:	Relationship to member:
Name:	Phone:
Address:	Relationship to member:
Name:	Phone:
Address:	Relationship to member:

Expiration and cancellation:

Unless canceled/revoked, this authorization will expire _____ (date or event) or **two years** from the date I signed this form, whichever is sooner. If preferred, I can write 'none' in the line above so that this form does not expire (while I am living and enrolled in an SHP and/or IHN-CCO plan).

I understand that I have the right to cancel (revoke) this authorization at any time. I may cancel this authorization by sending written notice to **SHP/IHN-CCO, PO Box 1310, Corvallis, OR 97339**. I understand that canceling this authorization will not affect any information SHP/IHN-CCO may have shared with my authorized representative(s) based upon this authorization.

Other important information:

This authorization allows SHP and/or IHN-CCO to **verbally discuss** my health information with my authorized representative(s) only. It **does not** allow disclosure of paper or electronic copies of my health plan record, nor does it allow electronic access to MyHealthPlan member portal.

Signing this form is completely voluntary. Access to benefits under my plan will never be withheld or conditioned on providing this authorization.

I understand that my authorized representative(s) may further share my health information without my authorization.

I have been offered a copy of the SHP and/or IHN-CCO Notice of Privacy Practices. I understand that this document, available at **samhealthplans.org**, describes my rights with respect to my health information, and how SHP and/or IHN-CCO can use and share my information.

Minors: In the state of Oregon, depending on their age, minors may be able to request certain levels of confidentiality or consent to various health care matters without parental consent. When a minor consents to care on their own, SHP and/or IHN-CCO may require the minor's authorization prior to discussing care, or payment related to that care, with the member's parent or legal guardian. This form, if signed by the minor, may be relied upon by SHP and/or IHN-CCO to discuss those care details with a minor member's parent or legal guardian. See ORS 109.675, ORS 109.610 and ORS 103.640 for more information.

The member's signature is required. If the member is a minor or is incapable of signing the authorization, a personal representative may be able to sign on the member's behalf. Legal documentation showing the authority of the personal representative may be required. Examples of acceptable documentation include: health care power of attorney, death certificate, or court order. This supporting documentation can be sent to Customer Service at the contact information below.

_____	_____	_____
Signature of member or legal representative	Relationship to member	Date

You are entitled to a copy of this authorization form after you sign it. Contact us if you would like a copy.

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

Fax: 541-768-9778

Mail: SHP/IHN-CCO
PO Box 1310
Corvallis, OR 97339

Visit us: 2300 NW Walnut Blvd., Corvallis, OR 97330
Monday through Friday, 8 a.m.to 5 p.m.