Interoperability allow/revoke authorized representative's access

With this form, 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 app. Please ensure the form is complete before submitting it. Missing information may result in your request being canceled until a new, completed form is submitted.

SHP/IHN-CCO member information:		
Last name:	First name:	MI:
Other name(s) used at any facility or provider:		
Date of birth (MM/DD/YYYY):	Member ID:	
Email:		
Note: All communication regarding this request will be conducted by email. Failure to provide an email address will result in the rejection of this form.		

Authorized representative information:		
For interoperability data sharing requested 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.		
Last name:	First name:	MI:
Address:		
City:	State:	ZIP:
Phone:	Email:	
Note: All communication from SHP/IHN-CCO regarding this request will be conducted by email. Failure to provide an email address will result in the rejection of this form.		

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 Access for:	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 to the app listed on the form. For each third-party app that you want to allow or revoke access to, a separate form must be submitted.		

My rights:

We at SHP/IHN-CCO understand that your protected health information is personal, and we are committed to protecting your privacy. We are obtaining this written authorization before we may use or disclose your information for the reasons listed below.

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

I understand I have the right to adequate notice of how the EHEI 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 redisclosure by the recipient and may no longer be protected under federal law. This authorization may be canceled (revoked) at any time.

To understand your privacy rights, please visit SHP/IHN-CCO privacy page at **samhealthplans.org/notice-of-privacy-practices**.

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 out more information about interoperability at SHP/IHN-CCO's education page at **samhealthplans.org/ThirdPartyApps** and IHN-CCO's education page at **IHNtogether.org/ThirdPartyApps**.

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

Add initials here: _____

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

Who is making this request? ☐ Member ☐ Authorized representative

Requester signature:	Date:

Requester printed name:

Form submission options:

- **Scan** completed, signed form and email to HealthPlanResponse@samhealth.org.
- **Mail** completed 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.