Eliance Health Solutions
Lancaster General Health

Please return completed form to:
Eliance Administrators, Attn: Customer Service
P.O. Box 7046, Lancaster, PA 17604-7046
Fax: 717-553-1125
Questions? Call 717-553-1124 or 1-855-408-8503

Authorization for Employee Access to Adult Dependent's Online Health Claim Information

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which was enacted to protect the privacy of individual's Protected Health Information (PHI), Eliance Administrators requires your written authorization to enable us to provide online access to your claims/and or enrollment information to the Subscriber (employee). If you are a spouse or dependent child age 18 and older, and would like to allow your Plan subscriber to have online access to your PHI through Eliance Administrator's claims/eligibility viewing system, please provide the information requested below and sign where indicated.

MEMBER INFORMATION	
Subscriber (employee) Name:	Family ID #:
Subscriber's Employer:	Last 4 Digits of Subscriber's Social Security Number:
Member (dependent) Name:	Member's Date of Birth:
Member's Daytime Phone Number:	Last 4 Digits of Member's Social Security Number:

DESCRIPTION OF PROTECTED HEALTH INFORMATION TO BE RELEASED

Entity authorized to release information: **Eliance Administrators**

Description of information to be released: Personal health care information, including health claims, benefits, eligibility for coverage and health plan information. This information could include sensitive categories, for example: mental/behavioral health or substance/alcohol addiction, HIV/AIDS, genetic information or reproductive health.

AUTHORIZATION AND SIGNATURE

I hereby authorize use or disclosure of protected health information about me as described below:

1. I authorize the covered Employee (subscriber) noted above to have access to my personal health claim information through Eliance Administrator's **Eliance Online Services System**.
2. I have read and understand what kind of information can disclosed to the Subscriber. I understand that disclosures could include information within those sensitive categories listed above
3. I understand that I am permitted to revoke this authorization, at any time, by notifying Eliance Administrators in writing, and this revocation will be effective for future uses and disclosures. However, I understand that this revocation will not be effective for information that was previously used or disclosed, relying on the authorization that was in force at the time.
4. I understand that this authorization will expire on the last day the plan is effective, or the last day of my coverage under the plan, unless I revoke this authorization, in writing, beforehand.

Signature of Member or Member's legal guardian or holder of power of attorney/legal representative*:	
Print Name:	Date Signed:

***If you are the Legal Guardian or holder of a power of attorney/legal representative for the member, please attach legal documentation.**

Official Use Only

Received	**Processed By**	**Log #**