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

Member Authorization to Release Claim and Benefit Information

This form provides permission for your Group Health Plan to discuss or release your protected health information to a person or organization that you choose in accordance with state privacy laws and the federal privacy law, Health Insurance Portability and Accountability Act (HIPAA). Your approval on this form limits the use of your information for that purpose only.

Section A. MEMBER INFORMATION	
Subscriber (employee) Name:	Daytime Telephone #:
Subscriber's Employer:	
Member's Name (if requester is not the subscriber)	Member's Date of Birth:
Family ID:	Last 4 Digits of Member's Social Security Number:
Section B. RECIPIENT (person or organization that will receive your information)	
Person's Name or Organization:	Daytime Telephone #:
Mailing Address:	Fax Number (if available):

Section C. DESCRIPTION OF PROTECTED HEALTH INFORMATION TO BE RELEASED
Entity authorized to release information: **Eliance Administrators**

Check **ONLY ONE** box:

☐ **Psychotherapy Notes** – Federal law requires a separate authorization to use or release psychotherapy notes. If you check this box, you may not check another box below.

☐ **All information related to the provision of and payment for my health care benefits***

☐ **Specific information as described below*** (for example: "the claim related to my service on (date);" "Appeal information related to my claim on (date)."

***NOTE:** State law requires that you give special permission to release certain sensitive information even if you checked a box above. Indicate your permission for the Group Health Plan to release any of the following information by initialing all that apply. Initialing is not a representation that such information exists.

Genetic Information _____ **Substance/Alcohol Abuse** _____
HIV/AIDS _____ **Mental/Behavioral Health** _____

Purpose of Release: _____

_____

(For example: "At my request;" "To resolve my appeal;" "To assist with my health coverage services.")

Section D. EXPIRATION AND REVOCATION

This authorization will expire: ☐ Date: or: ☐ Until revoked in writing

Unless otherwise specified above, this authorization will expire one year after the date this request was signed.

I understand I may revoke this authorization at any time by notifying Eliance Administrators at the address above. I understand that revocation will not have any effect on actions Eliance Administrators took before they received the revocation.

Your revocation will be effective within 5 business days of Eliance Administrators receipt of your written revocation.

Section E. AUTHORIZATION INFORMATION AND SIGNATURE

I understand that this authorization to release information is voluntary and is not a condition of enrollment in this Group Health Plan, eligibility for benefits or payment of claims. I also understand that if the individual or organization to receive the information is not subject to federal health information privacy laws, they may further disclose my protected health information and it may no longer be protected by federal privacy laws.

You or your Personal Representative must sign this authorization. Only one signature is required. If a Personal Representative signs the authorization, a copy of the legal documents showing they have authority to act on the member's behalf must be on file with the Group Health Plan or submitted with the authorization.

Member Signature. By signing below, I authorize the release of my protected health information as described above.

Print Name: _____ Date: _____

Signature: _____

Personal Representative Information. A Personal Representative is a person who has the legal authority to act on behalf of an individual. A copy of a Power of Attorney or other legal document must be on file at the Group Health Plan or submitted with this form.

Printed Name of Personal Representative: _____

Description of Representative's Authority: _____

Signature of Personal Representative: _____

Date: _____ Telephone Number: _____

You are entitled to a copy of this authorization form after you sign it.