HealthPlans, Inc.

# Authorization for Disclosure of Dependent's Protected Health Information

**Employer Name:** ______________________ **Group Number:** __________

In accordance with the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**), Health Plans, Inc. requires your written authorization to enable us to provide online access to your claims and/or enrollment information to your policyholder (plan subscriber).

If you are age 18 years or older, and would like to allow your plan subscriber to have online access to your Protected Health Information through Health Plans' claims/benefit viewing system, please provide the information requested below and sign where indicated. *(Please print or type all information.)*

## Plan Subscriber's Information

| *Plan Subscriber's Last Name* | *First Name* | *MI* | *Health Plans Member ID #* |
|---|---|---|---|
| | | | |

## Dependent's Information

| *Last Name* | *First Name* | *MI* | *Date of Birth* | *Relationship to Subscriber* |
|---|---|---|---|---|
| | | | | |

Please check the box below:

☐ I would like to grant online access to my claims and enrollment information to my plan subscriber (named above).

**Signature:** ______________________ ______________

*Signature of Plan Dependent* *Date Signed*

*The HIPAA Privacy and Security Regulations govern the use and disclosure of Protected Health Information (PHI). To comply with federal law, Health Plans, Inc. is required under HIPAA to obtain your authorization for others to access your PHI. If you provide such authorization, you may revoke the authorization* ***in writing****, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we had previously used or disclosed, relying on the authorization that was in force at the time.*