

Clover Health

Voluntary Authorization for Disclosure of Protected Health Information

This form allows people like your spouse, child, other family member or trusted friend, to discuss your health insurance benefits or healthcare with Clover representatives.

I authorize Clover Health (Clover) to share the health information I list below with the person or organization I name on this form. I understand once my health information is shared, it may not be protected by the person or organization I have named on this form, and may no longer be protected by law.

1. My Contact Information:	
Name:	
Date of Birth:	Phone Number:
Clover Member ID:	Email: (optional)

2. Contact Information of the Person or Organization I Want to Share My Information With: I authorize Clover to share my health information with the following person or organization:		
Name:	Organization (if applicable):	
Address:		
City:	State:	Zip
Phone Number:	Email: (optional)	FAX Number: (if applicable)

3. I authorize the following types of health information to be provided: Attach additional pages if necessary.	
<input type="checkbox"/> All health information (or select specific types of health information below):	
<input type="checkbox"/> Plan benefits or enrollment	<input type="checkbox"/> Payments (e.g. billing, claims)
<input type="checkbox"/> *Medical information	<input type="checkbox"/> *Prescription information
<input type="checkbox"/> *Lab results	<input type="checkbox"/> *Diagnostic test results
*In some cases, Clover may not have the full range of medical records as your doctor or hospital will have.	
Sensitive information (your initials are REQUIRED to share the following types of health information, please do NOT just check the boxes below or we will have to return the form to you for your <u>initials</u>):	
_____ Mental health records (initial)	_____ Genetic information (initial) (including genetic test results)
_____ Drug, alcohol, substance use treatment (initial) records	_____ HIV/AIDS, TB (tuberculosis), or STI (initial) (sexually transmitted infection) test results
_____ Other: _____ (initial)	

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4. How Clover Can Share My Information

Clover can share my health information in the following ways with the person or organization I named above (check all that apply):

Verbally, by phone conversation

And/OR Please send my records by: U.S. mail UPS/other carrier Secure email Fax

5. The reason I want to share my health information is for the following purpose: (check all that apply)

For Personal use

To allow my family member(s)/friend(s) to discuss my health information with Clover

To find additional medical care

For legal/insurance/disability purposes

Other: _____

6. This authorization will last until:

My last day as a Clover member OR (please enter a future date, e.g., December 31, 2040) _____
(Please note, permissions expire upon death.)

You have the right to take back your authorization at any time by sending a signed and dated written statement to Clover Health – P.O. Box 471, Jersey City, NJ 07303, saying that you (the member) are taking back your authorization to disclose your health information in the future. However, it is not possible for Clover to take back information that we've already shared. (If you have authorized us to share alcohol or substance abuse records, you may call us to take back your authorization.)

7. Signature

You can refuse to sign this authorization and your Clover health benefits will not be affected. However, we will not be able to share your health information without your signature.

Check here if you are signing as an authorized personal representative and provide your information below. Please attach the appropriate documentation (e.g., power of attorney, court order).

Please note: the documentation must be validated by our legal department before an authorized representative signature can be accepted.

Printed name: _____

Relationship to member: _____

Member Signature:

Today's Date:

Please mail this form to:
Clover Health
P.O. Box 471
Jersey City, NJ 07303

Or fax this form to:
ATTN: Mailroom
1-866-508-0865

Email this form as an attachment to:
PO_Box_471@cloverhealth.com