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:	
Address:		Unit Number: (if applicable)
City:	State:	Zip:
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:		Unit Number: (if applicable)
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.

☐ **All health information** (or select specific types of health information below):

- ☐ Plan benefits or enrollment
- ☐ Payments (e.g. billing, claims)
- ☐ *Medical information
- ☐ *Prescription information
- ☐ *Lab results
- ☐ *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 initials):

_____ (initial) Mental health records

_____ (initial) Genetic information (including genetic test results)

_____ (initial) Drug, alcohol, substance use treatment records

_____ (initial) HIV/AIDS, TB (tuberculosis), or STI (sexually transmitted infection) test results

_____ (initial) Other: _____

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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 21164, Eagan, MN 55121, 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 21164
Eagan, MN 55121

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