Clover Health

Voluntary Authorization for Disclosure of Protected Health Information

I voluntarily authorize Clover Health to disclose my protected health information listed below to the person(s) and/or organization(s) I have named on this form. I understand that my protected health information may be re-disclosed by the person(s) and/or organization(s), and may no longer be protected by law.

1. Contact information:	
Name:	
Date of Birth:	**Phone Number:**
Clover Member ID:	**Email:**

2. I authorize the following person(s) and/or organization(s) to **receive** my protected health information:			
Name(s):		**Organization** (if applicable):	
Address:	**City:**	**State:**	**Zip:**
Phone Number:		**Email:**	

3. I authorize the following types of information to be provided:
Authorization to disclose psychotherapy notes must be separate and cannot be combined with the release of any other information. Attach additional pages if necessary.

- ☐ **Plan benefits or enrollment**
- ☐ **Payments** (e.g. billing, claims)
- ☐ **All health records** (or select specific services below):
  - ☐ Physician's orders
  - ☐ Progress notes
  - ☐ Pathology notes
  - ☐ History/Physical exam
  - ☐ Allergies
  - ☐ Discharge summary
  - ☐ Past/Present medications
  - ☐ Operation reports
  - ☐ Diagnostic test results
  - ☐ Radiology reports
- ☐ **Sensitive information** (your initials are required to release the following):
  - _____ (initial) Mental health records (excluding psychotherapy notes)
  - _____ (initial) Genetic information (including genetic test results)
  - _____ (initial) Drug, alcohol, substance abuse records
  - _____ (initial) HIV/AIDS Test Results/Treatment, tuberculosis, or other STDs
- ☐ **Other:** _____

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4. The purpose or need for this disclosure is:

- ☐ Personal use
- ☐ Further medical care
- ☐ Attorney
- ☐ Insurance
- ☐ Disability
- ☐ School
- ☐ Research
- ☐ Other: _____

5. Duration of authorization:

This authorization shall be in force and effective until I am no longer a Clover Health member or _____, (date or event) at which time this authorization expires.

You have the right to take back ("revoke") your authorization in writing 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 revoking your authorization to disclose health records, except to the extent that the action has already been taken based on your permission. If you have authorized release of alcohol or substance abuse records, you may revoke verbally. If any other health record is being revoked, it must be done in writing.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction. I further understand that eligibility for health benefits, enrollment in a health plan, and treatment will not be affected by whether or not I sign this authorization.

☐ 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).

Printed name: _____

Relationship to member: _____

Signature:	**Date:**

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

Or fax this form to:
ATTN: Mailroom
1-551-226-5351

Email:
PO_Box_471@cloverhealth.com