Clover Health

Request for Access to Protected Health Information

Use this form to ask for a copy of your Protected Health Information (PHI) maintained by Clover Health to be sent to you or to another person, such as a family member. These records include medical and billing records, but do not include psychotherapy notes.

Section 1: Member Information	
Name:	
Date of Birth:	**Phone Number:**
Clover Member ID #:	

Section 2: Description of PHI Requested

Select the specific information or records you are requesting. (Check all that apply.)

- ☐ All medical records
- ☐ Claims
- ☐ Enrollment
- ☐ Case management and medical management
- ☐ Appeals and grievances
- ☐ Other (please describe): _____

I am requesting to receive a copy of my PHI for the dates of service below:

_____ to _____

MM/DD/YYYY MM/DD/YYYY

I am requesting that a copy of PHI about myself be mailed or faxed to the address or fax number below:

Address: _____

_____

_____

Fax Number: _____

PLEASE FILL OUT THE REVERSE SIDE OF THIS FORM.

Section 3: Signature of Member or Authorized Representative

By signing this form, I understand that Clover Health has thirty (30) days to respond, starting from the day the request is received. I understand that if Clover Health grants this request, in whole or in part, it will inform me of the acceptance of the request and provide a copy of the records requested. I understand that Clover Health has the right to deny the request, in whole or in part, and will provide me with a written denial. If my request for access to PHI is denied, I may have the right to request a reconsideration of the denial decision.

I also understand that this request does not apply to certain PHI, including (1) information that is not held in the designated record set; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of, or for use in, a legal action or proceeding; and (4) other health information not subject to the right to access under HIPAA.

☐ 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: _____

Signature:	**Date:**

Please mail the completed form to:
Clover Health
P.O. Box 21164
Eagan, MN 55121

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