Clover Health

Request for Restriction on Use and Disclosure
of Protected Health Information

Use this form to ask Clover Health to restrict the use or disclosure of your Protected Health Information (PHI) for certain aspects of treatment, payment, or healthcare operations.

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

Section 2: Requested Restriction
Description of the PHI you are requesting to be restricted:
Please explain the restriction you want to apply to that PHI.

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 will consider my request for restriction carefully. I also understand that Clover Health is not required to agree to a requested restriction but will accommodate reasonable requests whenever possible. If my request for restriction is approved, I understand that I can revoke my request in writing at any time. ❑ 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