Authorization to Disclose Personal Health Information

Use this form if you want Clever Care Health Plan to give your personal health information to someone other than you.

Section 1

Print Full Name (First & Last Name of the member)	**Member ID Number** (Exactly as shown on your ID card)	**Date of Birth** (mm/dd/yyyy)

Section 2

Clever Care Health Plan will only disclose the personal health information you want disclosed.

2A: Check only one box below to tell Clever Care Health Plan the specific personal health information you want disclosed:

☐ Limited Information (go to question 2b)
☐ Any information (go to question 3)

2B: Complete only if you selected "limited information". Check all that apply:

☐ Information about your Clever Care Health Plan eligibility
☐ Information about your Clever Care Health Plan claims
☐ Information about plan enrollment (e.g. drug or MA Plan)
☐ Information about premium payments
☐ Other Specific Information (please write below; for ex: payment information)

Section 3

Check only one box below indicating how long Clever Care Health Plan can use this authorization to disclose your personal health information (subject to applicable law—for example, your State may limit how long Clever Care Health Plan may give out your personal health information):

☐ Disclose my personal health information indefinitely
☐ Disclose my personal health information for a specified period only beginning:
____________________ and ending: ____________________
(mm/dd/yyyy) (mm/dd/yyyy)

Section 4

Fill in the name, address & phone number(s) of the person(s) or organization(s) to whom you want Clever Care Health Plan to disclose your personal health information. **Please provide the specific name of the person(s) for any organization you list below:**

Full Name:	
Address: (Street Address, City, State, and ZIP)	
Phone Number:	

Full Name:	
Address: (Street Address, City, State, and ZIP)	
Phone Number:	

Full Name:	
Address: (Street Address, City, State, and ZIP)	
Phone Number:	

Section 5

I authorize Clever Care Health Plan to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.

Signature	**Phone Number**	**Date** (mm/dd/yyyy)

Print the address of the person with a Clever Care Health Plan

Address: (Street Address, City, State, and ZIP)	

☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the person enrolled in Clever Care Health Plan signed above.

Print the Personal Representative's Information

Address: (Street Address, City, State, and ZIP)	
Phone Number:	
Relationship to the Beneficiary	

Section 6

Send the completed, signed authorization to:

Clever Care Health Plan
Attn: Compliance
8990 Westminster Blvd. Suite 300
Westminster, CA 92683

Section 7

Note: You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Clever Care Health Plan has already acted based on your permission. If you would like to revoke your authorization, send a written request to the address shown above. Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment or benefits.

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