Authorization to Disclose Protected Health Information

motivhealth®

Full Name _____ **Date of Birth** MO DATE, 2021

ID# _____

I authorize MotivHealth Insurance Company to disclose the following information:

- ☐ Enrollment, eligibility, benefit information
- ☐ Medical records and diagnosis
- ☐ Alcohol/substance abuse*
- ☐ Preauthorization
- ☐ Claims, claim status, and claim history
- ☐ Premium and billing information
- ☐ Appeal
- ☐ Other

This information may contain sensitive data, including data related to treatment of sexually transmitted diseases, HIV/AIDS, mental health, and reproduction or contraception (including prenatal care and abortion).

I authorize MotivHealth Insurance Company to disclose the information identified above to the following person(s) or entity(ies):

Name	_____	Name	_____
Relationship	_____	Relationship	_____
Address	_____	Address	_____
Phone	_____	Phone	_____

1. The purpose of this disclosure is: ☐ To assist me with my health plan ☐ Other
2. This authorization will expire two years from the date signed unless a shorter time frame is requested here:
   MO DATE, 2021

I may cancel this authorization at any time by sending written notice to MotivHealth Insurance Company, PO Box 709718, Sandy, UT 84070. Cancellation of this authorization will not affect any actions taken by MotivHealth Insurance Company before receiving my cancellation notice. I understand completing this authorization is not a condition to receive treatment, payment, enrollment, or eligibility. MotivHealth Insurance Company is not responsible for any action taken by an authorized recipient of my protected health information. I am aware that once MotivHealth Insurance Company discloses my information to an authorized recipient the privacy protections provided by law may no longer apply.

▶ _____ _____

Signed Dated

If you are signing this authorization on behalf of another individual, please complete the following and attach documentation demonstrating your authority to act on behalf of the individual (e.g., power of attorney, guardianship, conservatorship, etc.).

_____ ( ) _____ _____

Name of Personal Representative (please print) ▶ Phone Relationship

MO DATE, 2021

_____ _____

Signature of Personal Representative Dated

* **NOTE:** I understand that my substance abuse records are protected under Federal law (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in 42 CFR Part 2. I also understand that I may cancel this approval at any time, as described above.

Please return completed form to MotivHealth Insurance Company: PO Box 709718, Sandy, UT 84070