PROTECTED HEALTH INFORMATION (PHI) REQUEST FORM

motivhealth®

You may use this form to request a copy of your PHI or to authorize MotivHealth to share your information with another person.

If you need help completing the form, please contact our Personal Health Assistants (PHAs) at 844-234-4472 or PHA@motivhealth.com.

When Completed and signed please mail to: MotivHealth Insurance Company
P.O. Box 7009718
Sandy, UT 84070
You may also email this form to PHA@motivhealth.com or fax this form to: 844-533-1289.

Section I. The Member Access Request form is being requested for:			
Name of Member	Group ID #	Member ID #	
Social Security Number	Date of Birth		
Address	City	State	Zip Code
Telephone Number (XXX-XXX-XXXX)			

Section II. Please check the box for the records you wish to inspect or obtain a copy of and indicate date range:					
Enrollment Records	From:	To:	Health Records	From:	To:
☐ Application/Underwriting/ Attending Physician Statement Record (if applicable)			☐ Medical		
			☐ Dental		
☐ Premium Payment/Billing (if applicable)			☐ Prescription Drugs		
			☐ Vision		
			☐ Mental Health		
This Request CANNOT be used to disclose Psychotherapy Notes.					

Section III. Please choose which format you wish to receive/review your information.

Send my PHI to: (select only one)

☐ Me

☐ Designated Third Party: I request that MotivHealth send my PHI as specified in Section II above directly to the designated third party listed below.

Name	Address	City	State	ZIP	Phone Number

Format/Manner: (select only one)

☐ Send electronic copy. Note: Information will be sent to the email address provided below via secured (encrypted) email unless otherwise specified. Email Address:

☐ Send paper copy of information via US Mail.

☐ View in person. I understand that I or my designee will be contacted to arrange for this.

Section IV. Signature- This document must be signed by the Member or the Member's Personal Representative.

I request that MotivHealth provide access to my PHI as specified. I understand that I can only sign on behalf of a minor child under the age of eighteen (18).

Signature Date: month/day/year

Section V. If Section IV is signed by a Personal Representative, please complete the information below.

If you are signing as a Power of Attorney, Legal Guardian, Executor, or Administrator, please attach a copy of the legal documents.

Personal Representative's Name Relationship to Member

Personal Representative's Address City

Personal Representative's Phone Number Representative's Email

Any changes to the form must be approved by the privacy officer. Compliance@motivhealth.com