Protected Health Information (PHI) Disclosure Authorization Form

motivhealth®

Full Name: _____ Date of Birth: _____

ID #: _____

I authorize MotivHealth Insurance Company to disclose the following information:

☐	Enrollment, eligibility, benefit information	☐	Claims, claim status, and claim history
☐	Medical records and diagnosis	☐	Premium and billing information
☐	Alcohol/substance abuse*	☐	Appeal
☐	Only pharmacy claims	☐	Only medical claims
☐	Pre-authorization	☐	All of the above
☐	Other		

If you checked "Other," please explain: _____

_____

_____

_____

I understand that by submitting this form that 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 understand that I may sign into the MotivHealth website at any time and elect or change the authorized dependents who can view my information.

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

1. Name: _____

   Relationship: _____

   Street Address: _____

   City: _____ State: _____ ZIP: _____

   Phone: _____

2. Name: _____

   Relationship: _____

   Street Address: _____

   City: _____ State: _____ ZIP: _____

   Phone: _____

The purpose of this disclosure is: ☐ To assist me with my health plan ☐ Other

This authorization expires: _____
(Date or Event)

Note: If an expiration date is not indicated, this authorization will stay active for two (2) years from the signature date.

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.

Signature: _____ Date: _____

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: _____

Signature of Personal Representative: _____

Date: _____

***Note:** I understand that my substance abuse records are protected under federal law (43 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.