PHI Request Form

This form will allow me, a MotivHealth member, or my personal representative to request a copy of my Protected Health Information (PHI) for myself or for a designated third party.

If you need help completing the form, please contact our Personal Health Assistants at 844-234-4472. Please return a signed and completed form to:

MotivHealth Insurance Company
P. O. Box 7009718
Sandy, UT 84070

You may also email this form to correspondence@motivhealth.com or fax to: 844-533-1289.

Section I. Identification of Member Requesting PHI:		
Name of Member:		
Group ID #:	Member ID #:	
Social Security #:	Date of Birth:	
Address:		
City:	State:	ZIP:
Phone (xxx) xxx-xxxx:		

Section II. Select which records and a date range being requested.		
Enrollment Records	From:	To:
❑ Application/Underwriting/ Attending Physician Statement Record (if applicable)		
❑ Premium Payment/Billing (if applicable)		
Health Records	From:	To:
❑ Medical		
❑ Dental		
❑ Prescription Drugs		
❑ Vision		
❑ Mental Health		
This request CANNOT be used to disclose psychotherapy notes.		

Section III. Select individual and format of the information to be delivered.		
Send to: (select only one) ❑ Myself ❑ Designated Third Party (information listed below)		
Name:		
Address:		
City:	State:	ZIP:
Phone (xxx) xxx-xxxx:		
Format/Manner: (select only one) ❑ Electronic copy via secured (encrypted) email ❑ Paper copy via US Mail ❑ View in person. I understand that I or my designee will be contacted to arrange for this.		

Section IV. Signature of Member, Parent/Guardian, or Personal Representative	
I request that MotivHealth provides 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:
Printed Name:	
Relationship to Member:	

Section V. If signed by a Personal Representative, 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:	State:	ZIP:
Personal Representative's Phone:		
Personal Representative's Email:		

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

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