REQUEST FOR ACCOUNTING OF PROTECTED HEALTH INFORMATION (PHI) DISCLOSURES

You may use this form to request an accounting of how your Protected Health Information (PHI) was disclosed by MotivHealth or one of its Business Associates. The accounting will not include those disclosures exempted from accounting under the law. Those exemptions typically include disclosures:

- Made to carry out treatment, payment, or operations;
- To the patient or the patient's personal representative;
- That are incidental disclosures made in connection with a use or disclosure otherwise permitted or required by HIPAA;
- Made to person involved in a patient's care or as part of an inpatient directory;
- Pursuant to an authorization for release of information signed by the patient or patient's personal representative;
- For national security or intelligence purposes;
- To correctional institution or law enforcement officials under certain circumstances;
- As part of a limited data set, when the recipient has executed a data use agreement, disclosed for research, public health, or certain health care operations purposes;
- That occurred prior to April 14, 2003.

You are entitled to receive one (1) free Disclosure Accounting in a twelve (12) month period. Motivhealth may charge a fee to process additional requests received within that period. If you need help completing this form, please contact our Personal Health Assistants (PHA) 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. Please complete the following for the Member accounting being requested:			
Name of Member		Group	Identification/Subscriber#
Social Security Number	Date of Birth		
Address	City	State	Zip Code
Telephone Number (XXX-XXX-XXXX)			

Section II. Please list the range of time you want the accounting to include. Please note that the time period cannot exceed six (6) years prior to the date of request.	
From:	**To:**
Month/day/year	Month/day/year

Section III. Signature- This document must be signed by the Member or the Member's Personal Representative.	
I request that MotivHealth provide an accounting of my PHI disclosures as specified in Section II above. 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 IV. 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