Attestation Regarding Requested Use or Disclosure of PHI Potentially Related to Reproductive Health Care

MUST COMPLETE ENTIRE FORM TO BE VALID

PATIENT INFORMATION *Name, if practicable, or a description of the class of individuals whose PHI you are requesting	Patient Name:____________________ Address:________________ City, State, Zip Code:____________________ Phone Number: _(______)____________ Date of Birth: __________
PROVIDER/ORGANIZATION:	**I hereby authorize:** Name: ____________________ Address: ________________City, State, Zip Code:________________ Phone Number: _(______)__________
Description of Specific PHI Requested:	
REQUESTOR: *Includes Name or Class of Persons to receive the requested PHI	Name or Class: ____________________ Address: ________________City, State, Zip Code:________________ Phone Number: _(______)__________ Fax Number: ____________

I attest that the use or disclosure of PHI that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii) because of one of the following (check one box):

☐ The purpose of the use or disclosure of protected health information is <u>not</u> to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes.

☐ The purpose of the use or disclosure of protected health information <u>is</u> to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for such purposes, but the reproductive health care at issue was not lawful under the circumstances in which it was provided.

I understand that I may be subject to criminal penalties pursuant to 42 U.S.C. 1320d-6 if I knowingly and in violation of HIPAA obtain individually identifiable health information relating to an individual or disclose individually identifiable health information to another person.

______________________________ ________________

Signature of Person Requesting PHI *Date*

If you have signed as a representative of the person requesting PHI, provide a description of your authority to act for that person here: