Hartford HealthCare

Patient Name:
DOB:
MRN:

Backus Hospital ☐
Charlotte Hungerford ☐
Hartford Hospital ☐
MidState Medical Center ☐
Hospital of Central CT ☐
St. Vincent's Medical Center ☐
Windham Hospital ☐
_____Outpatient/Other ☐
Natchaug ☐
Rushford ☐

104507

(a location must be selected; if location changes, cross out, select new and initial)

Attestation for a Requested Use or Disclosure of Protected Health Information (PHI) Potentially Related to Reproductive Health Care

Background

Certain requests for PHI require a **signed attestation from the requestor** affirming that the requested use or disclosure is not for a **Prohibited Purpose** (defined below).

PHI potentially related to reproductive health care may not, under certain circumstances, be used or disclosed for the following **Prohibited Purposes**:

1. To conduct a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care.

2. To impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care.

3. To identify any person for any purpose described in (1) or (2) above.

The obligation to obtain an attestation from the requestor applies to the following requests for PHI :

- Requests for health oversight activities
- Requests in connection with judicial or administrative proceedings
- Requests for PHI from law enforcement
- Requests for PHI regarding decedents, for disclosure to coroners and medical examiners

ANY OF THE ABOVE REQUESTS FOR PHI WILL REQUIRE SUBMISSION OF A SIGNED ATTESTATION. AN ATTESTATION IS REQUIRED EVEN IF YOU ARE NOT SPECIFICALLY REQUESTING PHI RELATED TO REPRODUCTIVE HEALTH CARE.

Instructions

By signing the attestation, you are verifying that you are not requesting PHI for a **Prohibited Purpose** and acknowledging that criminal penalties may apply if untrue.

You may not add content to the attestation or combine the attestation form with another document except where another document is needed to support your statement that the requested disclosure is not for a Prohibited Purpose.

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ATTESTATION REGARDING A REQUESTED USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) POTENTIALLY RELATED TO REPRODUCTIVE HEALTH CARE

The entire form must be completed for this attestation to be valid.

Name of person(s) or class of persons to receive the requested PHI.
Name of person(s) or class of persons from whom you are requesting the use or disclosure.
Description of specific PHI requested, including name(s) of individual(s), if practicable, or a description of the class of individuals, whose PHI you are requesting.

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 PHI is **not** 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 of disclosure of PHI **is** 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.

_____ Date:_____ Time:_____

Signature of the person requesting the PHI

_____

Print Name

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

_____