Reproductive Health Care Attestation Form

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

Section 1: Description

HIPAA prohibits Covered Entities and their Business Associates from disclosing protected health information ("PHI") for the following 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).

This prohibition applies when the reproductive health care at issue (a) is lawful under the law of the state in which such health care is provided under the circumstances it is provided, (b) is protected, required, or authorized by Federal law, including the United States Constitution, under the circumstances in which such health care is provided, regardless of the state in which it is provided, or (c) is provided by another person and presumed lawful.

Section 2: Attestation and Legal Warning

By signing this attestation, you are verifying that you are not requesting PHI for a prohibited purpose and acknowledging that criminal penalties may apply if untrue.

Section 3: Instructions

1. You must complete every section of this form. The requested information will not be disclosed if the form is missing any required element or statement.
2. You may not add content that is not required or combine this form with another document except where another document is needed to support your statement that the requested disclosure is not for a prohibited purpose.
3. You must complete a new attestation for each specific use or disclosure request.

Section 4: Use or Disclosure Request

Name of person(s) or specific identification of the persons, or class of persons, to receive the requested use of disclosure of the PHI:

Name or other specific identification of the person, or class of persons, from whom you are requesting the use or disclosure of the PHI:

Description of specific PHI requested, including the name(s) of individual(s) whose PHI is requested. If providing the name(s) of the individual(s) whose PHI is sought is not practicable, include a description of the class of individuals whose protected health information you are requesting.

Section 5: Attestation and Signature

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 C.F.R. § 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 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 or disclosure of protected health information **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.

Signature of the person requesting the 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: