Catholic Health

REPRODUCTIVE HEALTH INFORMATION USE OR DISCLOSURE ATTESTATION

Authorization to Release Protected Health Information, REPRO. HEALTH HIPAA ATTESTATION, 11/7/24

FOR CATHOLIC HEALTH USE ONLY:

Date Received: _____

Date Processed: _____

Logged By: _____

Requestor Name (e.g., name of investigator, representative and/or agency making the request) **and Contact Information:**

Name of Catholic Health Entity / Individual Who Handles Requests for PHI (e.g., name of Catholic Health entity that maintains the PHI and/or name of their workforce member who handles requests for PHI):

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

☐ Patient Name (first and last) and, if known, their address, date of birth:

_____ _____
Name Date of Birth

☐ Class of Persons (describe):_____

Description of PHI Requested *(such as visit summary for [name of individual] on [date]; list of individuals who obtained [name of prescription medication] between [date range]). Attach additional information as necessary:*

Requestor's Attestation:

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 (select one):

☐ 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 USC § 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.

Requestor Signature:

_____ _____
Signature Date & Time

_____ _____
If signing as a representative of the Requestor, state authority to act Representative Contact Information (if different from Requestor Information above)

Important Information

When Catholic Health receives a request for PHI potentially related to reproductive health care, it must obtain a signed attestation that clearly states the requested use or disclosure is not for a prohibited purpose (as defined in 45 CFR 164.502(a)(5)(iii)(A)), where the request is for PHI for any of the following purposes: (i) Health oversight activities, (ii) Judicial or administrative proceedings, (iii) Law enforcement, and/or (iv) Regarding decedents, disclosures to coroners and medical examiners.

Catholic Health may not rely on this attestation to disclose requested PHI if any of the following is true:

- It is missing any required element or statement or contains other content that is not required.
- It is combined with other documents, except for documents provided to support the attestation.
- Material information in the attestation is false.
- A reasonable covered entity in the same position would not believe the requestor's statement that the use or disclosure is not for a prohibited purpose as described above.

Catholic Health must obtain a new attestation for each specific use or disclosure request, and maintain a written copy of the completed attestation and supporting documentation. The recipient may re-disclose the PHI received pursuant to this request, and this re-disclosure by the recipient may no longer be protected under Federal or NYS law.

All Persons Requesting PHI potentially related to Reproductive Health Care must:

1. Verify, by signing the attestation, that the request for PHI is not for a prohibited purpose and acknowledge that criminal penalties may apply if untrue.
2. Acknowledge that they may not add content that is not required or combine this form with another document except where another document is needed to support the statement that the requested disclosure is not for a prohibited purpose.

THIS ATTESTATION MUST BE ACCOMPANIED BY A VALID HIPAA AUTHORIZATION (IF REQUIRED BY LAW).
A COPY OF THIS ATTESTATION SHALL HAVE THE SAME FORCE AND EFFECT AS AN ORIGINAL.