Children's Hospital of Philadelphia℠

MR-224
Rev. 12/24

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

LAST NAME | FIRST NAME

MR# | DOB

PLACE PATIENT LABEL HERE *OR* COMPLETE ABOVE

DO NOT HANDWRITE PATIENT INFORMATION HERE

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

Name of person(s) or specific identification of the class of persons to receive the requested PHI. e.g., name of investigator or agency making the request
Name or other specific identification of the person or class of persons from whom you are requesting the use or disclosure.
Children's Hospital of Philadelphia
Description of specific PHI requested, including patient name(s), date of birth, and description of the type of information, such as visit date, whose protected health information you are requesting. If impractical to list all names, please provide a description of the class of individuals whose PHI is requested.

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 **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 | Printed Name | Date | Time

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