McLaren HEALTH CARE

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

I request that McLaren Health Care release the below patient information:

Patient Information	Release To:
Name:	Name of Requester:
Address:	Name of Agency, if applicable:
Date of Birth:	Address:
Date of Service:	Email Address:
Description of PHI 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. (*Note: Factual documentation supporting the statement that the reproductive health care was unlawful must be attached to this Attestation.)*

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 the PHI:

_____ Date: _____

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

_____

Signature of witness:

_____ Date: _____