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

Health Services
LOS ANGELES COUNTY

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

PATIENT INFORMATION (Type or print)			
Last Name:	**First Name:**		
Date of Birth:	**Last 4 digits of SSN:**		
Phone Number:	**Medical Record Number:**		
Street Address:	**City:**	**State:**	**Zip Code:**

Name of person(s) or specific identification of class of persons to receive the requested PHI.
Name or other specific identification of the person 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 protected health information 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 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.

PATIENT HIM LABEL
NAME
DOB
FIN#
MR#
SEX on ID

HSA-H1001

APPROVED FOR USE AT ALL DHS FACILITIES
SCAN INTO ELECTRONIC HEALTH RECORD

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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.

_____

_____

This attestation document may be provided in electronic format, and electronically signed by the person requesting protected health information when the electronic signature is valid under applicable Federal and state law.

PATIENT HIM LABEL

NAME

DOB

FIN#

MR#

SEX on ID

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