Compliance Office
401 Fifth Ave, Ste 1220
Seattle, WA 98104
206-263-8255 Fax 206-788-8433
TTY Relay: 711
www.kingcounty.gov/health

Public Health
Seattle & King County

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

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 and/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. *e.g., name of covered entity or business associate that maintains the PHI and/or name of their workforce member who handles requests for PHI*
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. *e.g., visit summary for [name of individual] on [date]; list of individuals who obtained [name of prescription medication] between [date range]*

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 un**lawful** in both Washington and the state in which it was provided 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.

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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:*

_____

Submit the completed attestation to the PHSKC Compliance Office.

401 Fifth Avenue, Suite 1220
Seattle, WA 98104
Phone 206-263-8255
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Email: dphroihotline@kingcounty.gov