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, signed, and dated for the attestation to be valid.

Requestor Information (Name, Address, Fax Number, and Phone Number of person requesting the information):
Health care provider releasing the records:
Public Health - Seattle & King County 206-263-9700
Patient and Records Information (Patient Name, Date of Birth, Type of Records, and Records Date Range):

I attest that the use or disclosure of Protected Health Information (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 ONLY ONE BOX. ATTESTATION WILL NOT BE ACCEPTED IF NO BOXES ARE CHECKED OR BOTH BOXES ARE CHECKED.***)

☐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; **or**

☐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 **unlawful** 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.

Public Health
Seattle & King County

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

*Signature of the person requesting the PHI (**SIGNATURE IS REQUIRED**)*

_____ Date _____

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

_____

Records will **not** be released until a completed and signed attestation is returned to our office.
Submit the completed attestation to the PHSKC Compliance Office.

401 Fifth Avenue, Suite 1220
Seattle, WA 98104
Phone 206-263-8255
IP Fax 206-788-8433
Email: dphroihotline@kingcounty.gov