Commonwealth of Massachusetts
Department of Mental Health

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

This 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 and address of investigator and/or agency making the request)*	
Name: _____	Attention: _____
Street: _____	Phone: _____
City/Town: _____	Fax: _____
State/Zip Code: _____	Email: _____

Department of Mental Health (DMH) Contact Information	
Attention: _____	
Street: _____	Phone: _____
City/Town: _____	Fax: _____
State/Zip Code: _____	Email: _____

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])*

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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.
*** See NOTE below**.

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: **Sign and provide information as required below**.

X _____ _____
Your signature Date

_____
Print name of signer

If you have signed as a representative of the person requesting PHI, provide a description of your authority to act for that person. (*e.g., title and name of agency)*

_____

This attestation document may be provided in electronic format, and electronically signed by the person requesting PHI.

*** NOTE to DMH Contact: Consult the Legal Department** to ensure compliance with Chapter 18, Section II (C) if the second box is checked. Provide any factual information supplied by the person requesting the use or disclosure of PHI that demonstrates a substantial factual basis that the reproductive health care was not lawful under the specific circumstances in which it was provided.

Distribution of copies: Original retained by DMH.