PATIENT IDENTIFICATION

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

Nationwide Children’s Hospital may not disclose protected health information (PHI) that is potentially related to reproductive health care without obtaining a valid attestation from the requestor that clearly states that the requested use or disclosure is not for any prohibited purpose described in 45 C.F.R. § 164.502(a)(5)(iii), where the request for PHI is for any of the following purposes:

1) Uses and disclosures for health oversight activities; 2) Uses and disclosures for judicial and administrative proceedings; 3) Uses and disclosures for law enforcement purposes; or 4) Uses and disclosures about decedents – coroners and medical examiners. This entire form must be completed for the attestation to be valid. The following information is required in order for us to process your request.

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) **CASA FRANKLIN COUNTY**

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)

#  CASA FRANKLIN COUNTY

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])

Child’s Name and Date of Birth

**Requesting Entire Legal Record** **FROM**: Child’s Date of Birth **TO:** PRESENT

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 (Initial) person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any

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person for such purposes.

 The purpose of the use or disclosure of protected health information is to investigate or impose liability.

(Initial) Please provide a brief description of the health care that was not lawful 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.

Signature of the person requesting the PHI Print Name Date/Time

#  Court Appointed Guardian ad Litem If

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

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| **Submit by Email:** | **Submit by Fax:** | **Submit by Mail:** |
| MedicalRecordRequests@NationwideChildrens.org | Health Information Management | Nationwide Children’s Hospital |
|  | (614) 355-0797 | Attn: HIM Dept. |
|  |  | 700 Children’s Drive |
|  |  | Columbus, OH 43205 |