Attestation: Use and Disclosure of Protected Health Information (PHI)

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

Requester Name _________________________ **Agency** _______________________ **Date** ___ /___ /____

Requesting protected health information from

[ ] University Hospital
[ ] Children's Psychiatric Hospital
[ ] UNM Medical Group, Inc.
[ ] UNM Psychiatric Center
[ ] UNM Cancer Center
[ ] UNM Sandoval Regional Medical Center
[ ] Carrie Tingley Hospital
[ ] Ambulatory Care

[ ] Other--please specify____________________________________

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:

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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), or by NMSA 1978, §24-35-3, 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.

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. Further, I understand that an omitted or false attestation will subject me to the jurisdiction of the New Mexico courts pursuant to NMSA 1978, §24-35-1, *et seq.*

Signature of requestor

____ Date _________________________

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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