



*The entire form must be completed for the attestation to be valid. Incomplete or ambiguous attestations may result in denial or delay of the requested disclosure.*

Name of person(s) or specific identification of the class of persons to receive the requested PHI.
Name or other specific identification of the person or class of persons from whom you are requesting the use or disclosure.
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.

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 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 health care, or to identify any person for such purposes, but the 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 and 42 CFR Part 2 Final Rule 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:

\_\_\_\_\_ 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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