Washington University Physicians®
in Illinois INC.

Health Information Release Services
660 South Euclid Ave., MSC 1219-35-3
St. Louis, MO 63110
Office: 314-273-0570 | Fax: 314-747-6041

Attestation for Use of Disclosure of Protected Health Information

Please check (✓) the appropriate box(es) (☐) and fill in the blank(s) as needed.

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

Name or other specific identification of the person or class of persons from whom you are requesting the use or disclosure:

☐Washington University School of Medicine in St. Louis
☐Other _____

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

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]

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.

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 *Date*

_____

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