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

By completing this attestation, you acknowledge that you are requesting PHI related to reproductive health care from AmeriHealth Caritas New Hampshire. This form is used to ensure that the sharing of PHI related to reproductive health care is not being used for a purpose prohibited by the HIPAA Privacy Rule. The entire form must be completed for the attestation to be valid. Please return completed forms to privacy@amerihealthcaritas.com.

Member information: (individual whose reproductive PHI will be shared)		
First Name:		Middle initial:
Last name:		Member ID:
Street address:		
City:	State:	ZIP code:
Date of birth:	Telephone number:	

Recipient information: (person or entity/organization that will receive the reproductive PHI)		
First name:	Last name:	
Entity/organization name:		
Street address:		
City:	State:	ZIP code:
Telephone number:		

Description of the PHI requested

I attest that the use or disclosure of PHI referenced above is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(S)(iii) because of one of the following. (Check one box.)

☐ The purpose of the use or disclosure of PHI 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 PHI *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 acknowledge that, by signing 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.

Requester signature:	Date:
Printed name of requester:	
If you have signed as a representative of the person requesting the PHI, provide a description of your authority to act for that person:	