UH2C726

Stony Brook Medicine

REQUESTED USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION POTENTIALLY RELATED TO REPRODUCTIVE HEALTH CARE ATTESTATION

Name of person(s) and/or organization to receive the requested Protected Health Information ("PHI"):
Name of covered entity or business associate from whom you are requesting the use or disclosure:
Description of specific PHI requested, including name(s) of individual(s), if applicable, or a description of the class of individuals, whose PHI you are requesting:

I attest that the use or disclosure of PHI I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii) because 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.

Printed name and signature of the person requesting the PHI:	**Date:**	**Time:**

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