The Alabama Department of Public Health's Attestation Regarding a Requested Use or Disclosure of Protected Health Information Potentially Related to Reproductive Health Care

Pursuant to a Final Rule effective December 23, 2024, to modify the Health Insurance Portability and Accountable Act of 1996 (HIPAA) Privacy Rule to support reproductive health care privacy, the Department must obtain a signed attestation. By signing this attestation, you are verifying that you are not requesting protected health information (PHI) for a prohibited purpose and acknowledge that criminal penalties may apply if untrue.

Name of person and or/agency to receive the requested PHI:			
First:	Last:	Agency (if any):	
Name of the Provider from whom you are requesting the disclosure of PHI:			
Name of the patient, date of birth and last four SSN of whose PHI you are requesting:			
First:	Last:	Date of Birth:	Last 4 of SSN:
Description of PHI requested:			

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 PHI _____ Date _____

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