Instructions for Completing the Attestation Regarding Protected Health Information Potentially Related to Reproductive Health Care

When HMSA receives a request for protected health information (PHI) potentially related to reproductive health care, HMSA must obtain a signed attestation if the PHI use or disclosure is for any of the purposes described below:

• Health oversight activities	• Law enforcement
• Judicial or administrative proceedings	• Regarding decedents, disclosures to coroners and medical examiners

Prohibited Purposes. HMSA may be prohibited from disclosing reproductive health care information when it will be used for any the following purposes:

1. To conduct a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care.
2. To impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care.
3. To identify any person for any purpose described in (1) or (2).

And:

a) the care/service provided is lawful under the law of the state in which such health care is provided under the circumstances in which it is provided,
b) the care/service provided is protected, required, or authorized by federal law, including the United States Constitution, under the circumstances in which such health care is provided, regardless of the state in which it is provided, or
c) the care/service is provided by another person and presumed lawful.

Information for the Person Requesting the PHI

1. **Please complete the attestation form included with these instructions**. Please ensure you complete all fields and sign the attestation form.
2. You may not add content that is not required or combine the attestation form with another document except where another document is needed to support your statement that the requested disclosure is not for a prohibited purpose. For example, if the requested PHI is potentially related to reproductive health care that was provided by someone other than the covered entity or business associate from whom you are requesting the PHI, you may submit a document that supplies information that demonstrates a substantial factual basis that the reproductive health care in question was not lawful under the specific circumstances in which it was provided.

3. **In addition, please provide the following information to help us fulfill your request more effectively:**

Information about you/the person requesting the PHI:

Requestor First Name	Requestor Last Name		
Name of Organization			
Address	City	State	ZIP
Email	Phone No.	Fax No.	

Information about the individual/health plan member whose information you are requesting:

HMSA Member First Name	HMSA Member Last Name
Member Date of Birth	HMSA Member ID #
Date range of information requested (*e.g., from 1/1/2024 to 3/30/2024*)	

4. **Attestation**
   If Box #2 is marked, please provide documents in support of the reproductive health care at issue that demonstrate the care/service provided was not lawful under the circumstances in which it was provided.

5. **Signature**
   Signature, name, and title of the person or organization who is requesting the information is required.

   If you are signing as a representative of the person or organization who is requesting the information, please provide information confirming your authority to act on behalf of the person or organization.

6. **Return Mailing Address**
   Please submit this completed instruction form and signed attestation form to: HMSA, P. O. Box 860, Honolulu, HI 96808-0860

   Please include the name of your HMSA contact if you have it.

*****HMSA will accept any valid attestation form for this purpose, providing the attestation meets all applicable regulatory requirements.

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

A completed attestation form is required for requests of protected health information (PHI) potentially related to reproductive health care in order to comply with HIPAA Privacy Rule requirements at 45 CFR 164.502(a)(5)(iii). HMSA must obtain a signed attestation from the requestor.

Please print legibly. Incomplete forms will not be processed. All sections must be completed unless otherwise specified.

REQUESTOR INFORMATION	
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*).	
Requestor First Name	Requestor Last Name
Name of Organization	

REQUESTING INFORMATION FROM	
Name or other specific identification of the person, class of persons from whom you are requesting the use or disclosure.	
Contact First Name	Contact Last Name
Name of Organization	

MEMBER INFORMATION
Description of specific PHI requested, including name(s) of the individuals if practicable, or a description of the class of individuals, whose protected health information you are requesting. (e.g., visit summary for [name of the 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):

☐ 1. 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.

☐ 2. 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*

_____ _____

Print name of the person requesting the PHI Title of the person requesting the PHI

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

This attestation document may be provided in electronic format, and electronically signed by the person requesting protected health information when the electronic signature is valid under applicable Federal and state law.

Please submit this form to: **HMSA, P. O. Box 860, Honolulu, HI 96808-0860**