LITTLETON REGIONAL HEALTHCARE

Attestation Regarding Requested Use or Disclosure of Protected Health Information Potentially Related to Reproductive Healthcare

Health Information Management Department
600 St. Johnsbury Road
Littleton, NH 03561
Phone: 603-444-9538 Fax: 603-259-7559
Email: HIMdept@lrhcares.org

Please complete all sections. Missing information may cause delays or the inability to retrieve the records. Releases may take up to 30 days to process.

Please Print **Patient Information** *Must be fully completed*	Name: _____ Previous Name: _____ Date of Birth: _____ Address: _____ City: _____State: _____ Zip: _____ Phone: _____
Requestor/ Agency who is requesting the records *Must be fully completed*	Requestor: _____Organization: _____ Address: _____ City: _____State: _____ Zip: _____ Phone: _____ Fax: _____ Email: _____
Name of Covered Entity that maintains the PHI *Must be fully completed*	**Please list the specific hospital, physician office and /or home health agency** Provider/Facility: _____ Address: _____ Phone: _____ City: _____State: _____ Zip: _____
Description of specific PHI requested	Date(s) of service From: _____ To: _____ ***We do not accept "ALL" for dates of service. If left blank the last 2 ~years will be sent.*** ***Check off the information you would like to be sent:*** ○Abstract (summary of visits and all tests) ○Emergency Department Visit(s) (Reports, tests, consults, etc.) ○Physician Office Visit(s) ○Radiology Reports ○Laboratory Report ○Operative Report ○Immunizations ○ Inpatient Stay(s) ○Nursing Notes ○ Urgent Care ○ Cardiology Reports and Stress Tests ○ Pathology ○ Rehab PT/OT/ST ○ Billing Records ○ Radiology Images ****Radiology Images will be available through Nucleus Online Portal through our Diagnostic Imaging Department*** ○Other _____ _____ _____

LITTLETON REGIONAL HEALTHCARE

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.

_____

Printed name of person requesting the PHI

_____ _____

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.

_____