ATTESTATION FOR USE AND DISCLOSURE REPRODUCTIVE HEALTH CARE INFORMATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LEGAL DIVISION
SFN 1696 (1-2025)

Clear Fields

This form is used to request Protected Health Information (PHI) potentially related to reproductive health care from a North Dakota Department of Health and Human Services (HHS) health plan, health care facility, or program providing health care. A separate form is required for each HHS health plan, health care facility, or program providing health care. Use SFN 1695 when HHS is requesting PHI potentially related to reproductive health care from an outside person or entity.

The entire form must be completed for the attestation to be valid.

Name of person(s) or specific identification of the class of persons to receive the PHI.			
Address	City	State	ZIP Code
Email Address		Telephone Number	

Name of HHS health plan, health care facility, or program providing health care that maintains the requested PHI.
Description of specific PHI requested, including name(s) of individual(s), if practicable, or a description of the class of individuals, whose PHI you are requesting.

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 (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 purpose.

☐ 2. The purpose of the use or disclosure of Protected Health Information (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 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.

Requestor/Representative Signature	Date
Print Name of Requestor/Representative	
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 may be provided in electronic format, and electronically signed by the person requesting PHI when the electronic signature is valid under applicable federal and state law.

FOR HHS USE ONLY

HHS REPRESENTATIVE: You are required to consult the HIPAA Privacy Officer if box #2 is checked on page one. Provide any factual information supplied by the person requesting the PHI that demonstrates a substantial factual basis that the reproductive health care was not lawful under the specific circumstances in which it was provided.

This form must be included in the client record and the disclosure accounted for.

Date Received	Date Processed
Printed Name of HHS Representative	Title
Comments	