# Requested Use or Disclosure of Protected Health Information Related to Reproductive Health Care

*The entire form must be completed for the attestation to be valid and in compliance with California Health & Safety Code 123100 et seq. and 45 C.F.R 164.508)*

**Patient Name** _____ **Date of Birth** ___/___/_____

**Phone** _____ **Email** _____

Name of Releasing Entity/Person:

❑ **University Faculty Associates, Inc.**

❑ Central California Faculty Medical Group, Inc. dba **Inspire Health Medical Group**

❑ **Inspire Health Medical Group – Cardiology**
2335 E. Kashian Lane, Suite 240, Fresno, CA 93701

❑ **Inspire Health Medical Group – Dermatology**
2335 E. Kashian Lane, Suite 410, Fresno, CA 93701

❑ **Inspire Health Medical Group – Endocrinology**
7085 N. Chestnut Avenue, Suite 101, Fresno, CA 93720

❑ **Inspire Health Medical Group – General Surgery**
1247 E. Alluvial Avenue, Suite 101, Fresno, CA 93720

❑ **Inspire Health Medical Group – Obstetrics and Gynecology**
2210 E. Illinois Avenue, Suite 408, Fresno, CA 93701

❑ **Inspire Health Medical Group – Orthopaedics**
604 N. Magnolia Avenue, Suite 100, Clovis, CA 93611

❑ **Inspire Health Medical Group – Perinatology**
2210 E. Illinois Avenue, Suite 301, Fresno, CA 93701

❑ **Inspire Health Medical Group – Psychiatry**
2210 E. Illinois Avenue, Suite 401, Fresno, CA 93701

❑ **Inspire Health Medical Group – Sleep Medicine**
6733 N. Willow Avenue, Suite 107, Fresno, CA 93710

❑ **Inspire Health Medical Group – Specialty Kashian**
2335 E. Kashian Lane, Suite 280, Fresno, CA 93701

❑ **Inspire Health Medical Group – Vascular Surgery**
1247 E. Alluvial Avenue, Suite 101, Fresno, CA 93720

❑ Other: _____

Street Address _____ Phone ___-___-_____

City/State/Zip _____ Fax ___-___-_____

Name of Receiving Entity/Person: _____

Street Address _____ Phone ___-___-_____

City/State/Zip _____ Fax ___-___-_____

**Information to Release (Check all that apply):**

❑ All Reproductive health information, including diagnosis, treatment, procedures, and prescriptions

❑ Specific reproductive health services (e.g., abortion, contraception, pregnancy-related care

❑ Other_____

By signing this form, I understand that the disclosed information may include sensitive details such as: Contraception and family planning services, pregnancy-related services, abortion care, STI/STD testing and treatment.

**Special Authorization Records (Check all that apply):**

❑ Behavioral Health ❑ HIV Test Results ❑ Substance Use Disorder

❑ Genetic Testing Results

**Dates of Service:** _____ or Date Range ___/___/_____ to ___/___/_____

**Purpose:** ❑ Personal Access ❑ Continued Care ❑ Other _____

**Requested Release Format:** ❑ Patient Portal ❑ Compact Disc *(CD)* ❑ Paper Copy

**Requested Release Method:** ❑ Mail ❑ Fax ❑ Email *(Encrypted)* ❑ In-Person

❑ Email *(Unencrypted - patient takes responsibility for increased risk of unauthorized access)*

**This authorization expires on** ___/___/_____ *(if blank, expires 1 year from date signed*

**Patient Rights:** *I understand that signing this authorization is voluntary. I have the right to receive a copy of this form after signing it. I understand that the disclosed information may no longer be protected under HIPAA if released to a third party, but California law may restrict further disclosure*.

**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)**:

❑ I am not investigating or imposing 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.

❑ I am investigation or imposing 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:

_____ ___/___/_____

Print Name Date

_____ _____

Signature of Patient or Legal Representative Relationship (if other than patient)

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.