GENERAL ATTESTATION REPRODUCTIVE HEALTH CARE INFORMATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LEGAL DIVISION
SFN 1695 (1-2025)

Clear Fields

This form is to be used by the Department of Health and Human Services (HHS) to request Protected Health Information (PHI) potentially related to reproductive health care from an outside person or entity. To make a request to a HHS health plan, health care facility, or program providing health care, use SFN 1696.

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

Name of person(s) or other specific identification of the class of persons to receive the requested PHI.
Name or other specific identification of the person or class of persons from whom you are requesting the use or disclosure.
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.	
Agency/Organization	Telephone Number