



Dear Requestor:

Thank you for your request for medical records from Nationwide Children's Hospital.

On December 23, 2024, a Federal HIPAA Privacy Rule related to reproductive health privacy went into effect. This privacy rule prohibits the use or disclosure of reproductive health information to investigate or impose liability on individuals for the mere act of seeking, obtaining, providing, or facilitating legal reproductive healthcare. The term "reproductive healthcare" is defined broadly and could potentially be included in any visit.

To that end, the law requires that Nationwide Children's Hospital obtain a valid, signed attestation form prior to disclosing protected health information potentially related to reproductive health care for the following purposes or activities:

- Health oversight
- Judicial and Administrative proceedings
- Law enforcement, or
- Disclosure about decedents to coroners or medical examiners

Because your request is related to one of the purposes/activities listed above, Nationwide Children's Hospital is requiring that you complete and submit the enclosed attestation, regardless of if it is anticipated that reproductive healthcare information is included in the request.

Please complete and sign the attached attestation form and submit it, along with your original request for medical records to the Release of Information Team. Upon receipt, we will continue processing your request.

We appreciate your understanding and anticipated cooperation.

If you have questions, please call 614-355-0797.

The Release of Information Team
Health Information Management Department
Nationwide Children's Hospital



NATIONWIDE CHILDREN'S

When your child needs a hospital, everything matters.®

PATIENT IDENTIFICATION

Attestation Regarding a Requested Use or Disclosure of PHI Potentially Related to Reproductive Health Care

Nationwide Children's Hospital may not disclose protected health information (PHI) that is potentially related to reproductive health care without obtaining a valid attestation from the requestor that clearly states that the requested use or disclosure is not for any prohibited purpose described in 45 C.F.R. § 164.502(a)(5)(iii), where the request for PHI is for any of the following purposes: 1) Uses and disclosures for health oversight activities; 2) Uses and disclosures for judicial and administrative proceedings; 3) Uses and disclosures for law enforcement purposes; or 4) Uses and disclosures about decedents – coroners and medical examiners. This entire form must be completed for the attestation to be valid. The following information is required in order for us to process your request.

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)

Name or other specific identification of the person or class of persons from whom you are requesting the use or disclosure. (e.g., name of covered entity or business associate that maintains the PHI and/or name of their workforce member who handles requests for PHI)

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

- ☐ _____ The purpose of the use or disclosure of protected health information is not to investigate or impose liability on any
(Initial) 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.
(Initial) Please provide a brief description of the health care that 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/Time

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

Submit by Email:

MedicalRecordRequests@NationwideChildrens.org

Submit by Fax:

Health Information Management
(614) 355-0797

Submit by Mail:

Nationwide Children's Hospital
Attn: HIM Dept.
700 Children's Drive
Columbus, OH 43205