**Satisfactory Assurances Statement for Judicial or Administrative Proceedings**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Requestor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As required by the Standards for Privacy of Individually Identifiable Health Information (“Privacy Regulations”) promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), this certification provides:

1. I am requesting that [COVERED ENTITY NAME] disclose protected health information (“PHI”) that will be used for a Judicial or Administrative Proceeding.
2. I have submitted a subpoena, discovery request, or other lawful process for the PHI (unaccompanied by a court order or express authorization), and this documentation is attached.
3. I have completed one of the following (check applicable section):
   * I have made reasonable efforts to ensure that the individual identified above, who is the subject of the information, has been given sufficient notice of the request, or the person authorized on his/her behalf has received such notice. I have made a good faith attempt to provide written notice to the individual/legal guardian. I certify that the notice included sufficient information about the litigation or proceeding in which the protected health information is requested to permit the individual to raise an objection to the court or administrative tribunal. I certify that the time for the individual to raise objections to the court or administrative tribunal has elapsed and either no objections were filed or all objections filed have been resolved and the disclosures sought are consistent with such resolution. Supporting documentation of these efforts is attached.

**OR**

* + I have made reasonable efforts to secure a qualified protective order. This was accomplished by the parties to the dispute agreeing to a qualified protective order and presenting it to the court/administrative tribunal; or the party seeking the PHI has requested a qualified protective order from the court/administrative tribunal. Supporting documentation of these efforts is attached.

**By signing this form, I attest to the facts as stated above.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Requestor Date

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| --- | --- |
| **[COVERED ENTITY] USE ONLY:**  Medical Record No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Requester identity verified?  \_\_\_ No \_\_\_ Yes, Officer ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date information released: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Unable to obtain signature? \_\_\_ Yes \_\_\_ No | **Information Released By:**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |