Kaleida Health

Internal Audit and Corporate Compliance

726 Exchange Street
Suite 200
Buffalo, New York 14210

January 7, 2025

Hon. Kevin M. Carter, District Administrative Judge
Eighth Judicial District of Western New York
Erie County Hall
92 Franklin Street
Buffalo, NY 14202

Re: Attestation Requirement

Dear Judge Carter:

The U.S. Department of Health and Human Services (HHS) has updated the HIPAA Privacy Rule to strengthen privacy protections regarding the reproductive health care of an individual to ensure that persons are not deterred from seeking, obtaining, providing, or facilitating reproductive health care where such health care is lawful under the circumstances where the health care services are sought or provided. *Please see* 45 CFR 164.502(a)(5)(iii), commonly referred to as "The HIPAA Rule to Support Reproductive Health Care Privacy."

These regulatory updates will have a direct impact on the way in which Covered Entities such as Kaleida Health and its Affiliates, respond to requests for protected health information in Judicial or Administrative proceedings including in response to Subpoenas and Court Orders.

Under the updated Rule, when a Covered Entity is asked to disclose protected health information *potentially related* to reproductive healthcare, they are now required to obtain an attestation from the requesting party affirming that the request is not related to investigations or proceedings concerning the seeking, obtaining, providing, or facilitating of reproductive healthcare that is lawful under the circumstances in which it was provided. *Covered Entities are prohibited from fulfilling the request for the disclosure absent the proper attestation.*

In anticipation of the upcoming enforcement date of December 23, 2024, enclosed is a copy of an attestation that must be executed when requests are made by Health Oversight Agencies, Law Enforcement, Coroners or Medical Examiners, or in Judicial or Administrative proceedings, for disclosure of protected health information that is potentially related to reproductive health care. This attestation consists of language required by HIPAA and may vary slightly in form from Covered Entity to Covered Entity.

We kindly ask that you share this new requirement with Members of the Bar, and any other parties you feel are appropriate to receive this, in order to ensure a smooth transition for all.

Very truly yours,

KALEIDA HEALTH

Victoria Belniak

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Chief Compliance and Privacy Officer
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Encl.

Kaleida Health

DOWNTIME ☐ Entered into electronic record after downtime

date _____ time _____

initials _____

ATTESTATION REGARDING A REQUESTED USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION POTENTIALLY RELATED TO REPRODUCTIVE HEALTH CARE

Patient ID Area

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

I attest that the use or disclosure of Protected Health Information (PHI) that I am requesting is not for a purpose prohibited by the Health Insurance Portability and Accountability Act (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 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 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.

Name of person(s) or 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 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])

Signature of the person requesting the PHI _____ **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.

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.