HARRISHEALTH SYSTEM

Certification for Law Enforcement PHI Request

Instructions: Please complete this form to request the disclosure of Protected Health Information (PHI) for law enforcement purposes when the request is **not accompanied by a court order or an authorization** signed by the patient or (his/her representative). See Harris Health System HIPAA Policy 3.11.306 *Permitted Use and Disclosure of Protected Health Information without Patient's Authorization.*

Patient Information:

Name: _____

Address: _____

City: _____ **State**: _____ **Zip:** _____

Date of Birth: _____

Social Security Number: _____**Medical Record Number**: _____

I hereby certify, as a law enforcement official requesting protected health information (PHI) for the above identified patient, that the following requirements under **45 CFR §164.512(f) (1) (ii)** have been met. Specifically, I certify the following requirements have been met:

1. The PHI sought is relevant and material to a legitimate law enforcement inquiry;
2. The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the PHI is sought; and
3. De-identified information could not reasonably be used instead of PHI.

Agency: _____

Address: _____

City: _____ **State**: _____ **Zip:** _____

Phone: _____

Print Name: _____

Signature: _____

Job Title: _____