

**AUTHORIZED INVESTIGATIVE DEMAND ATTESTATION**

(Attach this form to consent form, subpoena, warrant, summons or court order if applicable)

I, \_\_\_\_\_ of the \_\_\_\_\_  
(Law Enforcement Officer's Name) (Law Enforcement Officer's Agency)

hereby request that Clifton Fire Protection District disclose to me the patient information described below. I am conducting an official investigation into the commission of a crime and this is an official request for information for the reason checked below. I will use the information only to the extent authorized by law.

Name of Patient (if known): \_\_\_\_\_

Information Requested:

- Name and address
- Date and time of treatment
- Date and place of birth
- Names of treating facilities
- Social security number
- Date and time of death
- Type of injury, including extent and location
- Discharge Date
- Observations of intoxication or drug use (excluding lab results or breathalyzer results – only for Sections 1 and 2)
- Distinguishing physical characteristics (including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars and tattoos)
- Mental Health
- ABO blood type and Rh factor
- Other: \_\_\_\_\_
- DNA or DNA analysis, dental records, or typing, samples or analysis of body fluids or tissue (only for Section 1)

**HIPAA Uses and Disclosures for Law Enforcement Purposes**

Authorization for disclosure of protected health information is pursuant to 45 CFR §164.512(f).

**This Officer hereby attests to the following:** (Initial applicable section(s))

- 1. **Pursuant to Process (Warrants, Orders and Subpoenas).** 45 CFR §164.512(f)(1)(ii)(A)&(B). The information requested is based on (**Officer to check one**):  Court order,  Court-ordered warrant,  Subpoena issued by a judicial officer,  Summons issued by a judicial officer, or  Grand Jury Subpoena. (Attach copy of checked document). (No consent required.)
- 2. **Administrative Request.** 45 CFR §164.512(f)(1)(ii)(C). The information requested is relevant and material to a legitimate law enforcement inquiry. This request is specific and limited in scope to the extent reasonably practicable in light of the purposes for which the information is sought and de-identified information could not reasonably be used. This *Authorized Investigative Demand Attestation* is my written statement of legal authority. (No consent required.)
- 3. **Identification and Location.** 45 CFR §164.512(f)(2). The information requested will be used to assist in identifying or locating a suspect, fugitive, material witness or missing person. (No consent required.)

- 4a. **Victims.** 45 CFR §164.512(f)(3)(i). The information is about a patient who is a victim or suspected victim of a crime and the patient has consented to this disclosure. (See attached consent form.)

*(Reminder: This attestation form is not to be used for mandatory reporting of victims of abuse, neglect, or domestic violence. Health care providers must disclose protected health information (PHI) to a government authority, including a social services or protective agency, authorized by law to receive reports of such abuse, neglect, or domestic violence)*

- 4b. **Victims.** 45 CFR §164.512 (f)(3). The information requested is about a patient who is a victim or suspected victim of a crime (other than child abuse or adult neglect/abuse). It is not possible to obtain the consent of the patient because of incapacity or emergency circumstances. The information is needed to determine whether a violation of law has occurred by a person other than the patient. The information sought is not intended to be used against the patient. Immediate law enforcement activity depends on this disclosure, and the activity would be materially and adversely affected by waiting for the individual's consent. Additionally, the District has determined, in the exercise of professional judgment, that this disclosure is in the best interests of the patient. **(No consent required).**

*(Reminder: This attestation form is not to be used for mandatory reporting of victims of abuse, neglect, or domestic violence. Health care providers must disclose protected health information (PHI) to a government authority, including a social services or protective agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.)*

\_\_\_\_\_ (Signature of District Representative - Regarding 4b. only)

- 5. **Decedents.** 45 CFR §164.512(f)(4) permits health care providers to disclose protected health information about a decedent in order to alert law enforcement of the death if it is suspected that the death resulted from criminal conduct.

- 6. **Information Regarding Inmates.** 45 CFR §164.512(k)(5) The information requested is regarding an inmate or a person in lawful custody, that the law enforcement officer has lawful custody of the individual, and the information is necessary for:
  - treatment of the individual;
  - the health and safety of the individual or of other inmates;
  - the health and safety of the officers or employees of, or others at, the correctional institution;
  - the health and safety of those who are responsible for transporting inmates or transferring them to another institution, facility, or setting;
  - law enforcement on the premises of the correctional institution; or
  - the administration and maintenance of the safety, security and good order of the correctional institution.

**(No consent required.)**

*This request for disclosure of protected health information expires 30 days from the date of signature.*

\_\_\_\_\_  
Signature of Officer

\_\_\_\_\_  
Badge/ID #

\_\_\_\_\_  
Date

\_\_\_\_\_  
Case Number