AMERICAN MEDICAL RESPONSE

CERTIFICATE OF HIPAA SATISFACTORY ASSURANCES

(This certification must be completed fully and signed by an attorney to be valid.)

_____ _____
(Case Name) (Docket Number)

_____ _____
(Patient Name) (Patient medical record number/account number)

CERTIFICATION

I hereby certify that the representations below are true and correct based upon my personal knowledge; that I have reviewed the applicable privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164; that I have complied with the regulations and its requirements to obtain patient health information; and that I will comply with state and federal privacy laws as to any patient health information that I receive. I further certify the following:

1. I have used reasonable efforts and made a good faith attempt to notify patient or personal representative in writing by serving written notice of my intent to obtain patient's health information to patient or personal representative at this address:_____ (or if patient's location is unknown, to mail a notice to the patient's last known address listed above) by _____ on _____.
   Delivery method (fax, mail, etc.) Date

2. This written notice provided sufficient information about this litigation or proceeding in which the patient health information is requested to permit the patient or personal representative to raise objections in the appropriate court or administrative tribunal within the required time under Fla.R.Civ.P. 1.351 or other applicable rule from the date of service of the notice of intent.

3. The deadline for the patient or personal representative to object to the notice of intent under Fla.R.Civ.P. 1.351 or other applicable rule was set forth in the notice, which indicated that the deadline expired on _____.
   Date

4. Objections (Must initial one.)

   _____ A. Patient or personal representative did not file any objections.

   OR

   _____ B. Patient or personal representative filed objections with the court or administrative tribunal; the objections have been resolved by the court or administrative tribunal; there are no further objections pending or requiring resolution; and the disclosures of patient health information being sought are consistent with such resolution(s).

5. This certification is not being submitted to obtain mental health records, HIV test results, or substance abuse records.

6. I have attached the subpoena or other lawful process, and the notice of intent with this certification.

_____ _____ _____
Signature of Attorney (Must bear signature of attorney only) State Bar Number Date

_____ _____ _____
Print Name of Attorney Attorney Phone Number Party Represented

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Signature of Attorney
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State Bar Number
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_____ _____ _____
Print Name of Attorney
Attorney Phone Number
Party Represented