ATTESTATION of the DESTRUCTION and/or RETURN of PROTECTED HEALTH INFORMATION

Instructions: *Please complete the following Attestation for the record(s) of Northwest Health – La Porte. Return the completed attestation to the Facility Privacy Officer ("FPO") via personal delivery, mail, email, or fax at the below listed information provided by the FPO. If needed, the FPO will provide you with a pre-addressed, postage paid envelope to return records.*

1. My name is _____. All of the statements in this attestation are true and correct based upon my personal knowledge.

2. I received, obtained, or am in possession of records containing protected health information, not intended or authorized for me, from the above listed Healthcare Entity on or about _____ (Date). Records could be any type of media including but not limited to paper or electronic (e.g., fax, mail, email, text, photograph, video, recording) and will be referred to as "Records".

3. I represent that I have: (check all that apply)
   a. ☐ Returned all of the Records (preferred method), and/or
   b. ☐ Destroyed the Records by shredder on _____ (Date), and/or
   c. ☐ Permanently deleted the Records from the device and from any storage media for the device (e.g., deleted electronic communications in Sent, Inbox, Deleted/Trash, or other email folders; emptied Recycle Bins/Trash of previously deleted items; deleted information from back-up/cloud storage) on _____ (Date), and/or
   d. ☐ Permanently deleted social media post containing the Records, and/or
   e. ☐ Other, describe: _____

4. I further represent I have not retained copies of the Records; and I have not and will not further use or disclose the Records in any format (e.g., original, copied, electronic, paper, verbal, social media post such as Facebook, Twitter, YouTube, Instagram, etc.), make available, or provide to any individual or entity. However, if the Records were made available or provided to an individual or entity, I will fully disclose the details to the FPO.

_____	_____	_____
Signature	Date	Organization Name (if applicable)
_____	_____	_____
Printed Name	Title (if applicable)	Telephone

Return completed Attestation to: (FPO to fill in the blanks)
FPO Name: _____Rhonda Willis_____
Email: ___r.willis@nwhealthin.com_____ Fax Number: ____219.324.0108_____
Mailing Address: _1331 State St., LaPorte, IN 46350
Phone number for questions: ____219.344.6411___ Incident #: _51627_____