

REQUEST FOR RECORDS

A. REQUEST FOR RECORDS BY:

NAME LAST	FIRST	MIDDLE	TITLE
ORGANIZATION OR BUSINESS NAME IF APPLICABLE			
MAILING ADDRESS		CITY	STATE ZIP CODE
TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	E-MAIL ADDRESS	

B. REQUEST FOR RECORDS FROM: (PLEASE CHECK ALL THAT APPLY)

- | | |
|---|---|
| <input type="checkbox"/> Aging and Disability Services Administration | <input type="checkbox"/> Children's Administration |
| <input type="checkbox"/> Economic Services Administration assistance programs | <input type="checkbox"/> Division of Child Support |
| <input type="checkbox"/> Financial Services Administration | <input type="checkbox"/> Juvenile Rehabilitation Administration |
| <input type="checkbox"/> Medical Assistance Administration | <input type="checkbox"/> Division of Alcohol and Substance Abuse |
| <input type="checkbox"/> Division of Vocational Rehabilitation | <input type="checkbox"/> Mental Health Division including state hospitals |
| <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> All parts of the Department of Social and Health Services (DSHS) | |

C. REQUEST FOR CLIENT RECORDS OF:

<input type="checkbox"/> SELF <input type="checkbox"/> OTHER	NAME LAST	FIRST	MIDDLE
DATE OF BIRTH	FORMER NAMES		
CLIENT IDENTIFICATION NUMBER	OTHER IDENTIFICATION NUMBER	DATES OF SERVICE	LOCATION OF SERVICE

CLIENT RECORDS REQUESTED: Please specify records requested from DSHS programs marked above in Section B:

- Records on attached list
- The following records:
- All client records held by the DSHS programs marked in Section B.
- All client records held by DSHS for the named person.

List any limitations on records requested (by date, type of record, etc.):

D. REQUEST FOR OTHER DSHS RECORDS

I request the following DSHS records:

- Licensing records for the following facility or provider: _____
- Other records (describe as completely as possible, including by date, type of record, program, etc.):

E. ACCESS TO RECORDS (COMPLETE THIS SECTION FOR ALL REQUESTS)

- Please mail me copies of the above records. I understand DSHS may charge for copies of its records under WAC 388-01-080.
- Please contact me to arrange a time for me to inspect records at the following DSHS office: _____

NOTE: You must show proof of authority to obtain confidential records about others. Use Authorization form, DSHS 17-063, if needed to give permission.

REQUESTED BY (SIGNATURE)	DATE SIGNED
SIGNATURE OF WITNESS OR NOTARY VERIFYING IDENTITY IF REQUIRED	PRINTED NAME OF WITNESS OR NOTARY IF REQUIRED

If I am not the person who is the subject of confidential records, I am authorized to access these records because I am the: (attach proof of authority)

- Parent of minor Legal Guardian Personal representative Other:

OFFICE USE ONLY

DATE RECEIVED	RECEIVED AT:	DATE ACKNOWLEDGED	<input type="checkbox"/> ID VERIFIED HOW:	DATE RECORDS PROVIDED
---------------	--------------	-------------------	--	-----------------------