DSHS
WASHINGTON STATE Department of Social and Health Services

Request for Mental Health Service Information

RCW 70.02.260 requires mental health providers to release patient service information when requested on this form.

Request Date _____

☐ Initial request
☐ Follow up to oral request
(date of oral request: _____)

Name of Organization Information is Requested From				Phone Number (include area code)
Address	City	State	Zip Code	Email Address
Requestor's Name and Title				Phone Number (include area code)
Organization				Secure Fax Number (with area code)
Address	City	State	Zip Code	Email Address

Authority for Disclosure (check the appropriate boxes below)*

Requests for mental health service information under 70.02.260 are limited to:

☐ Law Enforcement Officer ☐ Therapeutic Court ☐ Indeterminate Sentence Review Board (ISRB)
☐ Public Health Officer ☐ Department of Corrections (DOC) ☐ Office of Public Defense
☐ County / City Jail ☐ Designated Mental Health Professionals

The patient / client:

☐ Is currently in custody or under supervision of DOC or ISRB.
☐ Has been convicted or found Not Guilty by Reason of Insanity of a serious violent offense.
☐ Is awaiting competency evaluation per 10.77.060.
☐ Was charged with a serious violent offense and the charge was dismissed under 10.77.086.
☐ None of the above (if checked, the information released will be limited to the fact, place, and date of an involuntary commitment, the fact and date of discharge or release, and the last known address).

The request is based on the requestor's reasonable suspicion that the patient:

☐ Is likely to commit a crime or violation of community custody or parole based on current or recent behavior.
☐ Is exhibiting signs of deterioration in mental functioning that may lead to civil commitment.

* At least one of each of the above three sections must be applicable (checked), otherwise other legal authority must be utilized or an authorization to release information must be obtained from the patient or legal representative prior to release of information.

Purpose for requesting information:

☐ Request is urgent. If request is more urgent than next business day, follow local emergent protocols
☐ Provide information within 15 working days:

Patient Health Information requested for:

Patient's Name / Aliases				Gender ☐ Male ☐ Female ☐ X	Date of Birth
Address	City	State	Zip Code	Social Security Number (last 4-digits)	

If known, patient's 6-digit DOC number: _____ or DSHS State Hospital Medical Record number: _____

Requested Information to be released by Mental Health Service Provider per RCW 70.02.260. Client ID Number:

Outpatient service records (current or most recent episode of services):

☐ Intake assessment ☐ Treatment plan ☐ Psychiatric medical evaluation/assessment

Inpatient psychiatric hospitalization (last admission): ☐ Discharge summary

10.77 – forensic: (last admission): ☐ Evaluation ☐ Treatment plan ☐ Discharge summary
☐ Psychiatric and psychosocial assessment ☐ Risk assessment plan

I declare the above to be true to the best of my knowledge, and that the information being requested is the minimum necessary for the purpose of carrying out the responsibilities of my office. I understand that any information I receive shall be held confidential and subject to the limitations on disclosure outlined in RCW 70.02.260. Email requests require encryption and electronic signature.

Requestor's Signature and Date

_____

_____

Instructions

Purpose of Form: To provide access to mental health information to law enforcement officers, jail personnel, designated mental health professionals, public health officers, therapeutic court personnel as defined in RCW 71.05.020, or department of corrections personnel (including the indeterminate sentence review board) . Information subject to release under RCW 70.02.260 must be requested during the course of the requesting organization's business and for the purpose of carrying out the responsibilities of the requesting person's office as described in RCW 70.02.260(3). Any information received under RCW 70.02.260 shall be held confidential and subject to the limitations on disclosure outlined in RCW 70.02.260.

Information provided under RCW 70.02.260 may not be sufficient to make clinical decisions regarding patient medical care.

RCW 70.02.260 does not limit the disclosure of patient information between health care providers as allowed under RCW 70.02.050.

Patient information released under RCW 70.02.260 shall not include psychotherapy notes or federally protected drug and alcohol and HIV/AIDS records.

Once submitted, mental health service providers, staff, or legal counsel shall not be liable for information released under RCW 70.02.260.

State Hospital Contact Information:

Eastern State Hospital ..... Phone: 509-565-4335 ..... Fax: 509.565.4605
Medical Record Department
Eastern State Hospital
PO Box 800
Medical Lake, WA 99022-0800

Western State Hospital ..... Phone: 253-582-8900 ..... Fax: 253-756-2963
9601 Steilacoom Blvd SW
Lakewood, WA 98498

Child Study and Treatment Center..... Phone: 253-756-2504 ..... Fax: 253-756-3911
8805 Steilacoom Blvd. SW
Lakewood, WA 98498

Office of Forensic Mental Health Services ..... Phone: 253-820-3013 Fax: 253-444-0636
1949 S State Street
Tacoma, WA 98405

Department of Corrections ..... Phone: 360-725-8859 ..... Fax: 360-586-0287
Public Disclosure Unit
PO Box 41128
Olympia WA 98504-1128