Washington State Department of Social & Health Services

Request for DSHS Records

A. REQUEST FOR DSHS 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 THESE DSHS PROGRAMS: (PLEASE CHECK ALL THAT APPLY)

- ☐ Behavioral Health and Recovery (DBHR)
- ☐ Child Support (DCS)
- ☐ Developmental Disabilities (DDD)
- ☐ Juvenile Rehabilitation Administration (JRA)
- ☐ Vocational Rehabilitation (DVR)
- ☐ Children's Administration (CA)
- ☐ Community Services (CSD – public assistance)
- ☐ Home and Community Services (HCS)
- ☐ Residential Care Services (RCS)
- ☐ State Mental Health Institutions (ESH, WSH, CSTC, SCC)
- ☐ Other: _____

C. REQUEST FOR DSHS CLIENT RECORDS OF:

☐ SELF ☐ 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.

List any limitations on DSHS 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.
- ☐ Other:

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	☐ ID VERIFIED HOW:	DATE RECORDS PROVIDED