

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 (BHA) <input type="checkbox"/> State Mental Health Institutions (ESH, WSH, CSTC) <input type="checkbox"/> Special Commitment Center (SCC) <input type="checkbox"/> Forensic Mental Health Services (OFMHS) <input type="checkbox"/> Other (i.e., Headquarters, RTFs): Economic Services (ESA) <input type="checkbox"/> Community Services (CSD – public assistance) <input type="checkbox"/> Child Support (DCS) <input type="checkbox"/> Disability Determination Services (DDDS) <input type="checkbox"/> Other (i.e., Headquarters): Office of the Secretary (OOS) <input type="checkbox"/> Enterprise Risk Management (ERMO) <input type="checkbox"/> Human Resources (DSHS Employee)		Aging and Long-Term Support (AL TSA) <input type="checkbox"/> Home and Community Services (HCS) <input type="checkbox"/> Residential Care Services (RCS) <input type="checkbox"/> Adult Protective Services (APS) <input type="checkbox"/> Other (i.e., Headquarters): Facilities, Finance, and Analytics (FFA) <input type="checkbox"/> Background Check Central Unit (BCCU) <input type="checkbox"/> Fraud and Accountability (OFA) <input type="checkbox"/> Leave / Payroll (DSHS Employee) <input type="checkbox"/> Developmental Disabilities (DDA) <input type="checkbox"/> Vocational Rehabilitation (DVR) <input type="checkbox"/> Other:		
C. Request for DSHS 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
RECORDS REQUESTED: PLEASE SPECIFY RECORDS REQUESTED FROM DSHS PROGRAMS MARKED ABOVE IN SECTION B: <input type="checkbox"/> All records held by parts of DSHS marked in Section B. <input type="checkbox"/> The following records only held by parts of DSHS marked in Section B:				
D. Request for Other DSHS Records				
I request the following DSHS records: <input type="checkbox"/> Licensing records for the following facility or provider: <input type="checkbox"/> Contract or procurement records for the following: <input type="checkbox"/> DSHS personnel or employment records related to (identify DSHS employee(s): <input type="checkbox"/> Describe other records requested as completely as possible, including by date, type of record, and program:				
E. Access to Records (Complete this section for all requests)				
<input type="checkbox"/> I understand DSHS may charge for copies of its records under WAC 388-01-080. <input type="checkbox"/> Please contact me to arrange a time for me to inspect records. <input type="checkbox"/> Other special requests:				
NOTE: You must show proof of your identity or authority to obtain confidential records. Use Authorization form, DSHS 17-063, to give permission to obtain records about other persons.				
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): <input type="checkbox"/> Parent of minor <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Personal or estate representative <input type="checkbox"/> Other:				
OFFICE USE ONLY				
DATE RECEIVED	RECEIVED AT:	DATE ACKNOWLEDGED	<input type="checkbox"/> ID VERIFIED BY:	DATE RECORDS PRODUCED