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|  |  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) [ ]  State Mental Health Institutions (ESH, WSH, CSTC) [ ]  Special Commitment Center (SCC) [ ]  Forensic Mental Health Services (OFMHS) [ ]  Other (i.e., Headquarters, RTFs): Economic Services (ESA) [ ]  Community Services (CSD – public assistance) [ ]  Child Support (DCS) [ ]  Disability Determination Services (DDDS)  [ ]  Other (i.e., Headquarters): Office of the Secretary (OOS) [ ]  Enterprise Risk Management (ERMO) [ ]  Human Resources (DSHS Employee) | Aging and Long-Term Support (ALTSA) [ ]  Home and Community Services (HCS) [ ]  Residential Care Services (RCS) [ ]  Adult Protective Services (APS) [ ]  Other (i.e., Headquarters): Facilities, Finance, and Analytics (FFA) [ ]  Background Check Central Unit (BCCU) [ ]  Fraud and Accountability (OFA) [ ]  Leave / Payroll (DSHS Employee)[ ]  Developmental Disabilities (DDA)[ ]  Vocational Rehabilitation (DVR)[ ]  Other:  |
| **C. Request for DSHS 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 |
| **RECORDS REQUESTED:** Please specify records requested from DSHS programs marked above in Section B:[ ]  All records held by parts of DSHS marked in Section B.[ ]  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:[ ]  Licensing records for the following facility or provider: [ ]  Contract or procurement records for the following: [ ]  DSHS personnel or employment records related to  (identify DSHS employee(s):  [ ]  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)** |
| [ ]  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 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): [ ]  Parent of minor [ ]  Legal Guardian [ ]  Personal or estate representative [ ]  Other:  |
| **OFFICE USE ONLY** |
| **DATE RECEIVED** | **RECEIVED AT:** | **DATE ACKNOWLEDGED** | **[ ]  ID VERIFIED****BY:** | **DATE RECORDS PRODUCED** |