Washington State Department of Social & Health Services
Transforming lives

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 Administration (BHA)
- ☐ Child Support (DCS)
- ☐ Developmental Disabilities (DDA)
- ☐ Vocational Rehabilitation (DVR)
- ☐ Special Commitment Center (SCC)
- ☐ Other:
- ☐ Community Services (CSD – public assistance)
- ☐ Home and Community Services (HCS)
- ☐ Residential Care Services (RCS)
- ☐ State Mental Health Institutions (ESH, WSH, CSTC)
- ☐ Human Resources and Payroll

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 described on attachment
- ☐ 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:
- ☐ Personnel or employment records of (list):
- ☐ 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