

Department of
Community and Human Services
401 Fifth Avenue, Suite 500
Seattle, WA 98104
(206) 263-9100 Fax (206) 205-6565
TTY Relay 711

REQUEST FOR ACCESS TO CLIENT INFORMATION

CLIENT INFORMATION

Client Name _____	**Previous Name / Alias** _____	**Client Date of Birth** _____	
Email _____	**Phone Number** _____	**Preferred Contact Method** _____	
Mailing Address _____	**City** _____	**State** _____	**ZIP Code** _____

YOUR RIGHTS

As a KC-DCHS client, you have the right to inspect, receive copies of, or request access to your client information, including protected health information (PHI). For PHI, these rights are provided by federal law (HIPAA); for other client information, DCHS applies the same standards under DCHS policy. You also may authorize another person or organization to receive your personal information on your behalf. These rights are described in the KC-DCHS Notice of Privacy Practices. We will respond to your request within 30 days of receiving it. If we need more time, we will notify you in writing of an extension of up to 30 additional days.

TYPE OF REQUEST

Please check all that apply so KC-DCHS can process your request.

- ☐ I want to receive copies of my client information by secure email.
- ☐ I want to receive copies of my client information by U.S. Mail.
- ☐ I want to inspect my client information in person or by another agreed method.
- ☐ I want to authorize another person or organization to receive my personal information. A separate authorization form is required. **Authorization to Use and Disclose Client Information (Form 1.6)**, available at [link to client facing webpage URL]. For behavioral health (BHRD) records, please use the BHRD release of information forms instead, available at https://kingcounty.gov/en/dept/dchs/human-social-services/behavioral-health-recovery/client-rights-privacy.

INFORMATION REQUESTED

I am requesting the following records. Check all that apply:

- ☐ KC-DCHS payment records
- ☐ KC-DCHS clinical records
- ☐ All information available in the DCHS designated record set, including payment and clinical records.
- ☐ Other specific records or information:(please describe)_____

_____

DIVISION(S) WHERE SERVICES WERE RECEIVED

Please check the DCHS division(s) where services were received. This helps us locate records. If you are not sure, leave this section blank or choose "Not sure."

- ☐ BHRD - Behavioral Health and Recovery Division
- ☐ DDECS - Developmental Disabilities and Early Childhood Supports Division
- ☐ ASD - Adult Services Division
- ☐ CYYAD - Children, Youth and Young Adult Division
- ☐ HCD - Housing and Community Development Division
- ☐ Not sure / I need information from all applicable DCHS divisions

DATES OF SERVICE

Specify the dates when services were received. If this section is left blank, KC-DCHS will provide available responsive records for all available dates.

From _____ **To** _____

FORMAT AND DELIVERY

- ☐ Electronic copy by secure email
- ☐ Paper copy by U.S. Mail
- ☐ Inspection only

_____

WHERE TO SUBMIT THIS FORM

Mail: King County Department of Community and Human Services
401 Fifth Avenue, Suite 500

Seattle, WA 98104
Attn: Privacy Officer

Email: DCHS_Privacy@kingcounty.gov

SIGNATURE

By signing below, I certify that I am the client or the client's authorized personal representative and that the information provided on this form is accurate to the best of my knowledge.

Signature of Client or Personal Representative _____

Date _____

Printed Name _____

Relationship to Client _____

If signed by a personal representative, describe your authority to act for the client and attach supporting documentation if requested:

_____

_____

FOR INTERNAL USE ONLY (KC-DCHS STAFF)

Date received _____

Date reviewed _____

Request status _____

Date communicated to client _____

Staff person processing request _____

_____

Request status: ☐ Accepted ☐ Denied ☐ Partially granted ☐ Clarification needed

Comments / basis for decision / follow-up needed:

_____

_____