

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 TO REVISE OR AMEND CLIENT INFORMATION

CLIENT INFORMATION

Client First Name _____	**Last Name** _____	**Client Date of Birth** _____
Record Number _____		

YOUR RIGHTS

As a KC-DCHS client, you have the right to ask us to correct your client information, including health information, if you think it is incorrect or incomplete. For PHI, this right is provided by federal law (HIPAA); for other client information, DCHS applies the same standards under DCHS policy. Please use this form to do this. If we cannot fulfill your request, we will tell you why in writing within 60 days.

Please tell us what information you want us to amend (change) or correct:

_____

_____

Please tell us why you think the amendment (correction) or change is appropriate or necessary. You must provide a reason.

_____

_____

DIVISION(S) WHERE SERVICES WERE RECEIVED

Please check the DCHS division where you received services. 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

HOW SHOULD WE SEND OUR WRITTEN RESPONSE?

Mailing address: _____
Email: _____
Phone: _____

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:

_____

_____

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

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:

_____