

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 RESTRICT ACCESS TO CLIENT INFORMATION

CLIENT INFORMATION

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

YOUR RIGHTS

As a KC-DCHS client, you have the right to ask us to restrict how we use or share your client information, including protected health information (PHI). 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 so. We are not required to agree to your request, with one exception: if you (or someone on your behalf, other than your health plan) paid for a service in full out of pocket and you ask us not to share information about that service with your health plan for payment or operations purposes, we must agree. If we agree to a restriction, we will follow it except in a medical emergency or where the law requires disclosure. We will respond to your request in writing.

ACTION REQUESTED

I am requesting that DCHS restrict access to the following records:

Please specify the information to be restricted:_____

_____

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

If known, where is this information located in your record?

_____

_____

How should this information be restricted?

_____

_____

Please explain why the entry should be restricted (optional - you are not required to give a reason):

_____

_____

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:

_____