

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 ACCOUNTING OF DISCLOSURES

CLIENT INFORMATION

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

YOUR RIGHTS

- As a KC-DCHS client, you have the right to request a list (called an “accounting”) of the times we’ve shared your client information, including health information, for six years prior to the date you ask, who we shared it with and why we shared it.
- We will include all the times we’ve shared your information, except for those about routine treatment, payment and health care operations.
- Please use this form if you want to request this accounting.

ACTION REQUESTED

I would like an accounting of disclosures for the following time frame. I understand that the maximum time frame that can be requested is six years prior to the present date.

From:			To:	

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

Address to which the accounting should be sent:

Physical address:

_____

_____

Email address:

_____

_____

I understand that the accounting will not contain disclosures that were made to carry out treatment, payment, or health care operations; disclosures to myself; disclosures to which I consented; and certain other disclosures that may be omitted according to law.

I understand that the accounting will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

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

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:

_____