King County

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 CONFIDENTIAL COMMUNICATIONS

CLIENT INFORMATION

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

Note this form is not for requesting a change of address.

YOUR RIGHTS

As a KC-DCHS client, you have the right to request to receive confidential communications of your client information, including health information, by alternative means or at alternative addresses. For PHI, this right is provided by federal law (HIPAA); for other client information, DCHS applies the same standards under DCHS policy. For example, if you do not want your appointment notices or your bills to go to your home where a family member might see it, you may ask us to communicate with you by another method or at an alternative location, such as a post office box. We will not ask you the reason for your request. We will accommodate all reasonable requests to receive communications from us by alternative means or at alternative locations.

If you ask us to communicate with you in a different manner or at a different location than we are now using, you must give us an alternative address or other method of contacting you (phone number, e-mail address, etc.).

Please indicate what method(s) of communication NOT to use. Check all that apply:

☐ Mail ☐ Phone ☐ Fax ☐ Email

Alternative address (postal or email)

_____

_____

Alternative phone number (if applicable)

_____

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:

_____