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| MHDlogo.jpeg | **Request for Mental**  **Health Service Information**  RCW 71.05.385 requires mental health providers to release patient service information when requested on this form. | REQUEST DATE    Initial request  Follow up to oral request  (date of oral request: ) | |
| **NAME OF ORGANIZATION INFORMATION IS REQUESTED FROM** | | PHONE NUMBER (INCLUDE AREA CODE) | |
| ADDRESS CITY STATE ZIP CODE | | EMAIL ADDRESS | |
| **REQUESTOR’S NAME AND TITLE** | | PHONE NUMBER (WITH AREA CODE) | |
| ORGANIZATION | | SECURE FAX NUMBER (WITH AREA CODE) | |
| ADDRESS CITY STATE ZIP CODE | | EMAIL ADDRESS | |
| **Authority for Disclosure (check the appropriate boxes below)\***  Requests for mental health service information under 71.05.385 are limited to:  Law Enforcement Officer  Therapeutic Court  Indeterminate Sentence Review Board (ISRB)  Public Health Officer  Department of Corrections (DOC)  County / City Jail  Designated Mental Health Professionals  The patient/client:  Is currently in custody or under supervision of DOC or ISRB.  Has been convicted or found Not Guilty by Reason of Insanity of a serious violent offense.  Was charged with a serious violent offense and the charge was dismissed under 10.77.086.  The request is based on the requestor’s reasonable suspicion that the patient:  Has engaged in activity indicating that a crime or a violation of community custody or parole has been committed.  Is likely to commit a crime or violation of community custody or parole based on current or recent behavior.  Is exhibiting signs of deterioration in mental functioning that may lead to civil commitment.  \* At least one of each of the above three sections must be applicable (checked) , otherwise other legal authority must be utilized or an authorization to release information must be obtained from the patient or legal representative prior to release of information.  Purpose for requesting information: | | | |
| Request is urgent. If request is more urgent than next business day, follow local emergent protocols  Provide information within six working days: | | | |
| **Patient Health Information requested for:** | | | |
| PATIENT’S NAME / ALIAS(ES) | | GENDER  Male  Female | DATE OF BIRTH |
| ADDRESS CITY STATE ZIP CODE | | SOCIAL SECURITY NUMBER (LAST 4 DIGITS) | |
| If known, patient’s six digit DOC number: or DSHS State Hospital Medical Record number: | | | |
| **Requested Information to be released by Mental Health Service Provider per RCW 71.05.385.**  Outpatient service records (current or most recent episode of services):  Intake assessment  Treatment plan   Psychiatric medical evaluation/assessment  Inpatient psychiatric hospitalization (last admission):  Discharge summary  10.77 – forensic: (last admission):  Evaluation  Treatment plan  Discharge summary  Psychiatric and psychosocial assessment  Risk assessment plan | | | |
| REQUESTOR’S SIGNATURE  I declare the above to be true to the best of my knowledge, and that the  information being requested is the minimum necessary for the purpose  of carrying out the responsibilities of my office. I understand that any information  I receive shall be held confidential and subject to the limitations on disclosure  outlined in RCW 71.05.385. Email requests require encryption and electronic signature. | | | |

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| **Instructions**  **Purpose of Form**: To provide the requesting person sufficient information to make decisions regarding the safety risk of a patient / client to self or others.  Information released by mental health providers under 71.05.385 must be requested during the course of the requesting organizations business and for the purpose of carrying out the responsibilities of the requesting person’s office.  Information provided under 71.05.385 may not be sufficient to make clinical decisions regarding patient medical care.  71.05.385 does not limit the disclosure of patient information between health care providers as allowed under 71.02.050.  Patient information released under 71.05.385 shall not include psychotherapy notes or federally protected drug and alcohol and HIV/AIDS records.  Once submitted, mental health service providers, staff, or legal counsel shall not be liable for information released under 71.05.385.  **State Hospital Contact Information**:  Eastern State Hospital Phone:  509-565-4335 Fax:  509.565.4605  Medical Record Department  Eastern State Hospital  PO Box 800  Medical Lake, WA 99022-0800  Western State Hospital Phone: 253-581-8900 Fax: 253-756-2963  9601 Steilacoom Blvd SW  Lakewood, WA.  98498  Child Study and Treatment Center Phone: 253-756-2504 Fax: 253-756-3911  8805 Steilacoom Blvd. SW  Lakewood, Washington  98498  Department of Corrections Phone: 360-725-8859 Fax: 360-586-0287  Public Disclosure Unit  PO Box 41128  Olympia WA 98504-1128 |