Department of Corrections
WASHINGTON STATE

REQUEST FOR HEALTH INFORMATION

Instructions: This form is to be completed by non-Health Services DOC employees and contract staff to request health information from DOC Health Services.

NAME (Last, First):	DOC NUMBER:	REQUEST DATE:
		Click to enter date.

Reason for requesting patient health information

Choose one

Type of information being requested

- ☐ Medications
- ☐ Medication compliance
- ☐ Ongoing health issues
- ☐ Physical limitations
- ☐ Work restrictions and duration
- ☐ Physical disability/mental impairment
- ☐ Accommodations required
- ☐ Mental health diagnoses
- ☐ Mental Health Appraisal
- ☐ Behavioral Health Discharge Summary
- ☐ Psychological evaluation
- ☐ Typed mental health notes
- ☐ Mental health treatment records (all)
- ☐ Other:

Date information needed by

Click to enter date.

REQUESTING STAFF NAME (FIRST AND LAST):	TITLE:	FACILITY/UNIT, FIELD OFFICE or HQ UNIT:

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.