



HEALTH RECORDS REQUEST CONTINUITY OF CARE

This form is to request records for continuity of care only.

Continuity of care records request is defined as: A request from a healthcare provider for medical, dental, and/or mental health information only. For the purpose of providing ongoing medical, dental, and/or mental health care. It may be from a doctor's office, hospital, county jail, prison, Veterans Health Administration, or other treating entity.

Please send completed form to DOCHealthInformation@doc.wa.gov or fax to 360-273-9420.

Requests for reasons other than continuity of care, or for information that would not be contained in a health record, must be submitted to the DOC Public Records Unit by email at docpdu@doc1.wa.gov and requires authorization by the patient.

REQUEST AND PATIENT IDENTIFICATION

*Date request made: _____

*Urgency of request: ☐ Urgent ☐ Routine

*Preferred delivery method: ☐ Mail ☐ Fax ☐ Secure email

*Patient's name (Last, First, MI): _____

Patient alias (Last, First, MI): _____

*Patient's date of birth: _____

DOC number (if known): _____

*DATES AND TYPE OF INFORMATION BEING REQUESTED

Date range of information being requested:

☐ All dates ☐ Last 2 years ☐ Other: _____

Type of information being requested:

<input type="checkbox"/> Medication list (recent)	<input type="checkbox"/> Outpatient notes	<input type="checkbox"/> Dental exam and notes
<input type="checkbox"/> DOC Health Care Summary	<input type="checkbox"/> Inpatient records	<input type="checkbox"/> Dental images
<input type="checkbox"/> TST results, TB treatment, chest x-rays	<input type="checkbox"/> Laboratory results	<input type="checkbox"/> Mental health notes
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Imaging reports	<input type="checkbox"/> Mental health assessments/evals
<input type="checkbox"/> Other (describe): _____		

REQUESTING HEALTHCARE PROVIDER'S INFORMATION

*Facility name: _____

*Mailing address: _____

Street/PO Box

City

State

Zip

*Requester's name: _____

*Phone (xxx-xxx-xxxx): _____ Fax (xxx-xxx-xxxx): _____

Email: _____

*Required

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.