West Mason Fire

P.O. BOX 2436, Shelton, WA 98584
(360)426-7343 Fax (360)426-2299

REQUEST FOR PUBLIC RECORDS

NAME OF REQUESTER: _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP _____

PHONE: _____ DATE OF REQUEST: _____ TIME: _____

NATURE OF REQUEST:

1. Identification of records*: _____

   _____

   _____

2. Inspection only _____
3. Number of copies requested _____

I declare under penalty of perjury under the laws of the State of Washington that I do not intend to use any list of individuals that may be covered by this request for commercial purposes.

Signature _____

*If the identified records include medical records of a District patient, you must also attach a patient authorization form. If you do not have the patient's consent, the records will be redacted unless you identify the legal basis under which patient consent is not required.

For Office Use Only: Date _____ Time _____

(1) Request Granted _____ Record Withheld ____ Record Redacted _____

(2) If consent is needed, name of individual: _____

(3) If withheld or redacted, identify the exemption contained in chapter 42.56 RCW or other applicable statue that authorizes the withholding of the record or part of record: _____

_____

(4) If withheld or redacted, explain how the exemption applies to the record withheld: _____

_____

Signature _____

West Mason Fire

P.O. BOX 2436, Shelton, WA 98584
(360)426-7343 Fax (360)426-2299

RCW 74.34.095 ..... Abuse of vulnerable Adults

RCW 82.32.330 ..... Disclosure of tax information

42 USC 290dd-2 ..... Confidentiality of Substance Abuse Records

42 USC Sec 12101 et.seq..... Americans with Disabilities Act

29 USC Sec 657 et seq.....Occupational Safety and Health Act

Most of the Federal or State agencies that administer the above acts have adopted regulations to implement the acts. The regulations must be reviewed together with the acts when reviewing record requests.

Authorization for Release of Information

Washington State Health Care Authority

1 Health Care Authority is authorized to release information or records about

Last name, First name, Middle initial | Client I.D. or Social Security number

Address | City | State | ZIP Code

Phone number

If release is for information about dependent child(ren), list name(s) of dependent child(ren)

Reason/purpose for disclosure

At the request of the individual Other:

Specific information to be used or disclosed (including dates, if needed; attach additional pages if more space needed)

The following types of information must be specifically authorized. This authorization includes information about the following (check all that apply):

Sexually transmitted diseases

Mental health

HIV/AIDS test results, diagnosis, or treatment

Chemical dependency treatment

Notice to those receiving information: If these records contain information about HIV/AIDS, sexually transmitted diseases, or drug or alcohol abuse, you may not further disclose that information under federal and state law without specific permission from the person and meeting specific legal requirements.

This authorization will expire in 180 days from the date signed below or on (give date or event)

2 Person or organization authorized to receive information or records

Name | Phone number

Address | City | State | ZIP Code

3 Signature

I have read and understand the following statements about my rights:

- I may cancel this authorization at any time before the expiration date or event noted above by notifying the Health Care Authority in writing. The cancellation will not affect any information either received or given by the Health Care Authority before the cancellation notice was received.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive health care benefits, such as enrollment, treatment, or payment. If I do not sign this form, the Health Care Authority may not release my information to any person or organization except those needed to determine my continued coverage, eligibility and enrollment, or as allowed by law.
- The person or organization that I authorize to receive information about me or my dependent child(ren) might share it with another person or organization, and it might not be protected under the laws that apply to HCA.
- The Apple Health Notice of Privacy Practices and UMP Notice of Privacy Practices are available upon request by calling (844) 284-2149 or at **hca.wa.gov/pages/privacy.aspx**.

Form must be completed before signing. If signed by representative provide power of attorney or proof of guardianship.

Signature of enrollee or enrollee's representative — Date

Signature of child (if age 13 or older) representative — Date

Printed name of enrollee's representative — Relationship to enrollee

Provide copy of power of attorney or guardian papers.

Please return completed form to:

If Washington Apple Health (Medicaid) or CHIP
Health Care Authority
P.O. Box 45534
Olympia, WA 98504-5509

Email: **askmedicaid@hca.wa.gov**
Fax: 360-507 9068

If Public Employees Benefits Board Program or School Employees Benefits Board Program:
Health Care Authority
P.O. Box 42684
Olympia, WA 98504-2684

Email: **ERBCORR@hca.wa.gov**
Fax: 360-725-0771

If subrogation:
Health Care Authority
P.O. Box 45561
Olympia, WA 98504-5561

Email: **HCACasualtyUnit@hca.wa.gov**
Fax: 360-753-3077

If request for disclosure of records:
Health Care Authority
P.O. Box 42704
Olympia, WA 98504-7204

Eamil: **PublicDisclosure@hca.wa.gov**
Fax: 360-507-9068

If constituent relations:
Email: **HCAConstituentRelations@hca.wa.gov**