IDAHO DEPARTMENT OF
HEALTH & WELFARE

Request for Alternate Means of Delivery

Please complete and return this form to a Department of Health and Welfare office.

Available in Spanish. We provide interpreter services at no cost. Call 2-1-1 or 1-800-926-2588 for interpretation assistance.
Disponible en espanol. Proveemos servicios de intérprete sin costo alguno. Llame al 2-1-1 ó al 1-800-926-2588 para obtener la ayuda de un intérprete.

Client Name_____ Client Date of Birth _____
(First, MI, Last)

Client Home Address _____

Client Mailing Address (if different) _____

Client Telephone _____

Requestor Name (if different than client) _____

Requestor Telephone _____ Requestor Fax Number (optional) _____

Please list where you would like us to send our response to your request.

Name _____

Address _____

The information that I would like to receive using a different mailing address: _____

_____

_____

The different mailing address is: _____

_____

Time period for which I would like the information identified above be delivered to the different mailing address:

_____

The Department will notify you in writing if we are unable to respond to your request within 10 days.

If this request is being made by someone other than the subject of the information, please describe and provide documentation of your authority to request an alternate means of delivery of that person's information _____

_____

Your signature _____ **Date requested** _____

Your signature must be notarized if you submit this request by mail or fax.

I, _____, being a Notary Public, do hereby certify that on this day _____ of _____, 20_____, the above individual, having been first duly sworn, appeared before me and signed the foregoing document.

_____
Signature of Notary Public

Notary Public residing at _____
My commission expires on _____

For DHW Office use only
- ○ ID Provided _____
- ○ Form Complete _____

Authority:
- ○ Accessing own records _____
- ○ Documentation Attached _____
- ○ Not Required _____