INSTRUCTIONS FOR COMPLETING A STANDARD TORT CLAIM FORM:

- Type or print clearly in ink and sign the Standard Tort Claim form.
- Provide all requested information and any available documents or evidence supporting your claim, such as medical records or bills for personal injuries, photographs, proof of ownership for property damages, receipts for property value, etc.
- If the requested information cannot be supplied in the space provided, please use additional blank sheets so your Standard Tort Claim form can be easily read and understood.
- If you are presenting a personal injury claim, please sign and attach the Medical Release form.
- If your claim involves a motor vehicle accident, please complete, sign, and attach the Vehicle Collision Form.
- State law requires an original signature on the Standard Tort Claim form. This means Standard Tort Claim forms cannot be submitted electronically (fax or e-mail). See presenting information below.
- **Present in Person or Mail the Standard Tort Claim Form and Supporting Documents to:**

The City of East Wenatchee
City Clerk
271 9th St. NE
East Wenatchee, WA 98802
Business hours: Monday - Friday 8:00 a.m. to 5:00 p.m.

CITY OF EAST WENATCHEE

Standard Tort Claim Form

As mandated by Chapter 4.96 RCW, this form is for filing a tort claim against the City of East Wenatchee. Some of the information requested on this form is required by RCW 4.96.020 and may be subject to public disclosure. Standard Tort Claim forms cannot be submitted electronically (via e-mail or via fax).

Please type or print in ink.

Mail or deliver original form to:

The City of East Wenatchee
City Clerk
271 9th St. NE.
East Wenatchee, WA 98802

1. Claimant Information:	
Full Name	
Former Names/Aliases	
Driver's License Number	
Claimant's actual residence at the time the incident occurred:	
Street Address	
City, State, Zip Code	
Claimant's current, actual residence:	
Street Address	
City, State, Zip Code	
Home Phone Number	
Work Phone Number	
E-mail Address	

2. Incident Information:	
Date of Incident	
Time	
Location	
City department alleged responsible for damage/injury	
City employee alleged responsible for damage/injury	

3. Names, addresses, and telephone numbers of all persons involved in or witnesses to incident:		
Name	*Address*	*Phone number*

4. Names, addresses and telephone numbers of all individuals not already identified in #3 above that have knowledge regarding the liability issues involved in the incident, or knowledge of the Claimant's resulting damages. Please include a brief history as to the nature and extent of each person's knowledge. Attach additional sheets if necessary.

5. Describe the cause of Claimant's injuries or damages. Explain the extent of property loss, of physical injuries, of emotional injuries, or of mental injuries. Attach additional sheets if necessary.

6. Has this incident and reported to law enforcement, safety or security personnel? If so, when and to whom?

7. Please identify the names, addresses and telephone numbers of treating medical providers. Please attach copies of all medical reports and billing.

Name	*Address*	*Telephone number*

8. Please attach each document which supports the claim's allegations.

9. I claim damages from the City of East Wenatchee in the sum of:

$____

This claim form must be signed by the Claimant, the person holding a written power of attorney from the Claimant, by the attorney-in-fact for the Claimant, by an attorney admitted to practice in Washington State on the Claimant's behalf, or by a court-approved attorney or guardian ad litem on behalf of the Claimant.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

____________________________________ ____________________________________

Signature of Claimant | Date

____

Place of Signing (residential address, city, and county)

Authorization for Release of Protected Health Information (PHI) to the City of East Wenatchee

Name: ____
(Last, First, Middle Initial or Middle Name)

Date of Birth: Month _____ Day ____ Year _________

I hereby authorize disclosure of my protected health information to the City of East Wenatchee ("City"), for purposes of processing my claim for damages filed with the City.

I understand that by signing this document, I authorize the release of the following information:

- Complete medical record for all services, including history and physical exam; progress notes; x ray reports; inpatient admissions; operative notes; physical or other therapy; laboratory and other test reports; physician and physician assistant orders; nursing notes; and all other records and references designated by the provider as part of its medical record.
- HIV Test Results and medical information related to HIV testing or treatment.
- Psychiatric, mental and behavioral health records, including treatment notes, assessments, testing documents and results, and medical records related to mental health diagnosis and treatment.
- Alcohol assessment, testing, referral or treatment records.
- All other chemical dependency assessment of treatment records.
- Pharmacy prescriptions and reports.
- All letters and memos received or sent, including electronic mail, referencing my treatment.
- Information related to alleged sexual assault or sexually transmitted disease, including test results.
- Urgent care, outpatient or other clinic visit information.
- Gynecological and/or obstetrical information.
- All client records generated for or by governmental programs of which I am a client. Identify the program(s) and agency: ____.
- Financial records related to my care and treatment.

I understand the following: **(PLEASE READ AND INITIAL ALL STATEMENTS)**

_____ I understand that my records are protected under HIPAA/PHI regulations (federal law) and the Washington State Health Care Information Act (RCW 70.02).

_____ I understand that my health information may be subject to re-disclosure by the City and not protected for purposes of evaluating and investigating the claim I have filed with the City.

_____ I understand that the specific information to be disclosed in my medical record may include information regarding alcohol, drug or other controlled substance use, counseling referrals and/or a history of testing or treatment of acquired immune deficiency syndrome.

_____ I understand that I may revoke this authorization at any time by notifying the City in writing, and that the revocation will be effective as of the date the City receives it. Any records obtained pursuant to this Authorization for Release of PHI prior to the revocation will be deemed authorized by me for release.

_____ I understand that this Authorization for Release will expire 90 days from the date I sign it. I can also authorize a different time frame for this release to be valid. This permission is valid until my claim is resolved or closed by the City.

A Photocopy of this Authorization carries the same authority as the original for purposes of releasing my records to the City.

Signature of Authorizing Individual:

____

Date of Signature: ____

Telephone number: ____

Witness (where patient is over 13 and signing the release):

____

Where the signer is not the subject of the records:

I am authorized to sign this because I am the (attach proof of authority):

- ☐ Parent of minor
- ☐ Legal Guardian
- ☐ Personal Representative
- ☐ Other

To the Provider or Records Custodian:

Please send legible copies of all records to:
The City of East Wenatchee
City Clerk
271 9th St. NE
East Wenatchee, WA 98802