Children's Division- Medical Record Collection Request

Show Me Healthy Kids
MANAGED BY HOME STATE HEALTH

Are you a Health Information (HIS) Specialist? ☐ Yes ☐ No If No, please route request to your regional HIS Specialist

Patient's Full Name and Previous Names Used	Date of Birth	DCN (if known)

Patient Street Address	City	State	Zip Code

Information To Be Released: (Check all that apply)

☐ Outpatient clinic, inpatient, or ER visit for the following date or date range: _____

☐ History and physical only

☐ Visit list only

☐ Immunization records only

☐ Facesheet/demographic data only

☐ Other: (exact documents and/or date ranged needed)
_____
_____
_____

☐ Entire health record (includes all electronic and paper documents including non-clinical, does not include images)

☐ Images: (indicate date range)
Radiology: _____ Cardiology: _____
Neurology: _____ Other: _____

☐ Genetic information, services, or tests

☐ AIDS or HIV data and records

☐ Mental health data and records (but not psychotherapy notes)

☐ Alcohol and drug information

If request is for a specific provider, please provide the below: (If more space is needed, please feel free to include an attachment)

Provider Name: _____

Provider Address: _____

Provider Phone #: _____

Provider Fax #: _____

Provider Tax ID or NPI (*Only if Known*): _____

Please submit to your local HIS. https://dss.mo.gov/docs/settlment-2019/his-circuit-map.pdf