MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
MISSOURI STATE PUBLIC HEALTH LABORATORY

101 NORTH CHESTNUT STREET, PO BOX 570
JEFFERSON CITY, MO 65101
(573) 751-3334 Fax: (573) 522-8155
http://health.mo.gov/lab/index.php

INSTRUCTIONS - PATIENT ACCESS FORM

Below are INSTRUCTIONS for completing the Patient Access Form. The Patient Access Form is after the instructions.

All requests must be accompanied by a completed Authorization for Disclosure of Consumer Medical Health Information form. If legal guardian, you must provide a copy of the guardianship papers. If legal representative, you must provide a copy of the power of attorney for health care.

REQUEST INFORMATION SECTION

Patient Name: Enter the patient's Last Name, First Name and Middle Initial at the time the test was performed.

Patient Date of Birth: Enter the patient's Date of Birth in the following format MM/DD/YYYY.

Patient Address: Enter the patient's address, Street and/or PO Box, at the time the test was performed.

Patient City, State, Zip: Enter the patient's city, state and zip code at the time the test was performed.

Clinic/Hospital Name where specimen was collected: Enter the name of the facility where the specimen was collected. If requesting a Newborn Screening result report(s), enter the name of the facility where the infant was born.

Date of Specimen Collection: Enter the date the specimen was collected in the following format MM/DD/YYYY.

Name of Test(s) Ordered: Enter the specific name of the test that was ordered by the facility. You may need to contact the facility to request the name of the test requested.

If requesting Newborn Screening result report(s), Biological mother's name at time of child's birth: Enter the birth Mother's Last and First Name at the time the child was born.

Biological mother's address at time of child's birth: Enter the Biological mother's address at the time the child was born.

REQUESTOR INFORMATION SECTION

Name: Enter your last and first name

Phone Number: Enter your phone number to which you can be reached if the Missouri State Public Health Laboratory (MSPHL) has questions.

Address: Enter your address. If requesting to have the result report(s) mailed, this is the address to which the result report(s) will be sent.

City: Enter your city. If requesting to have the reports mailed, this is the city to which the results will be sent.

Zip: Enter your zip code. If requesting to have the result report(s) mailed, this is the zip code to which the result report(s) will be sent.

E-mail Address: Enter your e-mail address if you are requesting to have the result report(s) e-mailed. THE RESULT REPORT(S) WILL BE ENCRYPTED IF SENT VIA E-MAIL.

Your relationship to the person named on record: Enter your relationship to the patient.

Requestor's Signature & Date: Sign and date the Patient Access Form.

Requested Format: Check the appropriate Format box in which you prefer to receive the result report(s). CD - compact disc.

Requested Delivery Options: Check the appropriate Delivery option in which you prefer to receive the result report(s). If E-mail is selected, the e-mail will be encrypted.

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PATIENT ACCESS FORM

Print | Reset Form

Applicants must complete and submit the Authorization for Disclosure of Consumer Medical Health Information (Health Insurance Portability and Accountability Act (HIPAA) Authorization for Disclosure) form in addition to the Patient Access Form when requesting copies of laboratory test result report(s) from the Missouri State Public Health Laboratory (MSPHL). If a legal guardian, a copy of the guardianship papers must be provided. If a legal representative, a copy of the power of attorney for health care must be provided.

REQUEST INFORMATION In order to assure patient identification in compliance with HIPAA, the MSPHL requires the completion of the following information.

Patient Name: _____ (Last Name) _____ (First Name) _____ (MI)
Patient Date of Birth: _____ (MM/DD/YYYY)

Patient Address: _____

Patient City, State, Zip: _____ (City) _____ (State) _____ (Zip Code)

Clinic/Hospital Name where specimen was collected: _____
Date of Specimen Collection: _____ (MM/DD/YYYY)

Name of Test(s) Ordered: _____

If requesting Newborn Screening result report(s),

Biological mother's name at time of child's birth: _____ (Last Name) _____ (First Name)

Biological mother's address at time of child's birth: _____

REQUESTOR INFORMATION Result report(s) will be sent to this address.

Name: _____ (Last Name) _____ (First Name) _____ (MI)
Phone number: _____ (XXX) XXX-XXXX)

Address: _____ City: _____ State: _____ Zip Code: _____

Email Address(if result report(s) sent via e-mail): _____

Your relationship to the person named on record (If legal guardian, must provide guardianship papers. If legal representative, must provide power of attorney for health care). _____

I _____ (Requestor Last and First Name), subject to the penalty of perjury, do solemnly declare and affirm that I am eligible to receive a copy of the laboratory test result report(s) requested above and that the information contained in this form is true and correct to the best of my knowledge.

Requestor's Signature: _____ Date: _____

Requested Format: ☐ Paper ☐ CD Requested Delivery Options: ☐ Email ☐ Mail

FOR MSPHL STAFF USE ONLY

Log Number: _____ Received Date: _____

Authenticated Date: _____ Sent Date: _____

Staff who completed request: _____