**Section 411.740 Health Records**

a) The child's or youth's health record shall, where appropriate, contain the following:

1) The completed receiving screening form;

2) Health appraisal data forms;

3) All findings, diagnoses, treatments, and dispositions;

4) Prescribed medications and their administration;

5) Laboratory, x-ray, and diagnostic studies;

6) Signature and title of documenter;

7) Consent and refusal forms;

8) Release of information forms;

9) Place, date, and time of health encounters;

10) Health service reports, such as, dental, mental health, and consultation reports;

11) Treatment plan, including nursing care plan;

12) Progress reports; and

13) Discharge summary of hospitalization and other termination summaries.

b) The method of recording entries in the records, the form and format of the records, and the procedures for their maintenance and safekeeping shall be approved by the facility director.

c) The facility shall have a written plan that upholds the principle of confidentiality of the health record and supports the following requirements:

1) The active health record shall be maintained separately from the child or youth master record file.

2) Access to the health record shall be controlled by the facility director. Department personnel shall have unrestricted access to a child's or youth's medical record.

3) The Qualified Mental Health Professional (QMHP) shall share with the facility director information regarding a child's or youth's medical management, security, and ability to participate in programs.