



Directive to Destroy Newborn Screening Test Results and/or Blood Sample

By signing this form, I understand that I am choosing to have newborn screening for my child, but am requesting the bloodspot and/or test results to be destroyed.

(Parent or guardian: Check below the box or boxes that apply.)

Directive to destroy newborn screening test results and or bloodspots

- Destroy my child's newborn screening bloodspot(s).
- Destroy my child's newborn bloodspot screening test results stored at the Minnesota Department of Health.
- Destroy my child's newborn hearing screening test results stored at the Minnesota Department of Health.

(Parent or guardian: Read and initial each statement below.)

I, the parent or guardian of the infant named below, understand that:

If I choose to have my child screened then have his or her blood sample destroyed, the blood sample will be unavailable for any future medical or forensic identification use. *Initial here:* _____

Destroying the Minnesota Department of Health's copy of my child's newborn blood screening test results may limit future access to them by physicians and may necessitate duplicative testing. *Initial here:* _____

Name of infant:	Birth date:
Hospital or place of birth:	

Parent or guardian signature: _____

Parent or guardian printed name: _____

Relationship to child: _____ Date: _____

Street address: _____

City: _____ Zip: _____ Phone: _____

Send completed form to:

Minnesota Department of Health
Newborn Screening Program
P.O. Box 64899
St. Paul, MN 55164-0899

Phone: (800) 664-7772
Fax: (651) 201-5471
E-mail: newbornscreening@health.state.mn.us
Website: www.health.state.mn.us/newbornscreening