# Individual Request for Newborn Screening Blood Spots
# Authorization to Release Healthcare Information

**Individual Information**

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|---|---|
| First & Last Name: | Birth date: |
| Birth Mother's First & Last Name: | Mother's Birth Date: |
| Hospital or Place of Birth: | |
| Phone: | |

**Please Release Newborn Screening Blood Spots To:**

| | |
|---|---|
| Name of Individual, Clinic, or Organization: | |
| Street Address: | City, State, & Zip Code: |
| Phone: | Fax: |

**I understand the following:**

- Some portion of the blood spots will be released to the person, clinic, or organization named above.
- Once the spots are released to the person, clinic, or organization named above, the Minnesota Department of Health cannot prevent them being shared with a third party. At that point, the specimens may no longer be protected by state and federal privacy laws.
- To be valid, this form must be filled out completely and signed by the individual or the legal guardian of a minor. A copy is valid if it has not been altered.
- ***For results to be released, identity of the requesting individual must be authenticated either by an attached copy of a photo ID or by a notary public.***

_____ _____

*Printed Name of Individual or Legal Guardian* *Date/Time*

_____ _____

*Signature of Individual or Legal Guardian* *Notary Public Signatory*

Send or fax 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) 215-6285
Email: newbornscreening@health.state.mn.us
Website: www.health.state.mn.us/newbornscreening