DEPARTMENT OF HEALTH
NEWBORN SCREENING

Request to Release
Authorization to Release Newborn Screening Card

REV 02/2025

Child's name (first & last):

Birth date:

Birth mother's name (first & last):

Hospital or place of birth:

I understand the following:

- By completing and returning this form, I request the above-named child's used newborn screening card(s) be released to the health care provider and/or clinic named below.
- Once the newborn screening card(s) are released to the health care provider or clinic, the Minnesota Department of Health cannot control whether the provider or clinc shares the card(s) with others. Contact the provider of clinic if you have questions about their privacy policies and practices.
- To be valid, this form must be filled out completely and signed by the individual or the legal guardian of the minor. A copy is valid if it has not been altered.

Requesting parent/guardian's printed name (first & last):

Parent or guardian signature:

Relationship to child: Today's date:

Street address:

City:

State: Zip: Phone:

Health Care Provider or Clinic Mailing Address

Attention:

Address line 1:
Street address

Address line 2:
Apartment, suite, unit, building, floor, etc. (unable to deliver to P.O. boxes)

City:

State: Zip: Phone:

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: health.newbornsceening@state.mn.us
Website: www.health.state.mn.us/newbornscreening