DEPARTMENT OF HEALTH
NEWBORN SCREENING

Release Request
Authorization to Release Newborn Screening Test Results

REV 01/2025

Individual Information

Newborn First and Last Name:

Newborn Birth Date:

Birth Mother First and Last Name:

Mother Birth Date:

Hospital or Place of Birth:

Clinic Phone Number:

Please Release Newborn Screening Test Results To:

Individual, Clinic, or Organization:

Street Address:

City, State, and ZIP Code:

Phone Number:

Fax:

I understand to the following:

- All test Results will be released to the person, clinic, or organization named above.
- Once the records are released to the person, clinic, or organization named above, the Minnesota Department of Health cannot prevent them from being shared with a third parth. At that point, the records may no longer be protected by the 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, identify 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 Signature

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