DEPARTMENT OF HEALTH

Individual Request for Newborn Screening Test Results
Authorization to Release Healthcare Information

Individual Information

First and Last Name:	Birth Date:
Birth Mother's First and Last Name:	Mother's Birth Date:
Hospital or Place of Birth:	
Phone Number:	

Please Release Newborn Screening Test Results To:

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

I understand 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 party. At that point, the records 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.***

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Printed Name of Individual or Legal Guardian

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Date/Time

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Signature of Individual or Legal Guardian

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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
E-mail: newbornscreening@health.state.mn.us
Website: www.health.state.mn.us/newbornscreening

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