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

Individual Information

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

08/2019