DEPARTMENT OF HEALTH

Request for Newborn Screening Test Results Consent to Release Test Results

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

Please Release Newborn Screening Test Results To:

Name of Health Care (Person, Clinic, or Organization):	
Street Address:	City, State, and Zip Code:
Phone:	Fax:

I understand the following:

- All test results will be released to the health care provider named above.
- Once the test results are released to the health care provider named above, the Minnesota Department of Health cannot prevent the test results from being shared with a third party. At that point, the test results may no longer be protected by state and federal privacy laws.
- To be valid, this form must be filled out completely and signed by theparent or guardian. A copy is valid if it has not been altered.
- ***For test results to be released, identity of the parent or guardian must be authenticated either by an attached copy of a photo ID or by a notary public.***

Parent or guardian signature: _____

Parent or guardian printed name: _____

Relationship to child: _____ Date: _____

Street address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Notary Public Signature or Valid Photo I.D. _____

Send or fax completed form to:
Minnesota Department of Health
Newborn Screening
P.O. Box 64899
St. Paul, MN 55164-0899

Phone: (800) 664-7772
Fax: (651) 215-6285
E-mail: health.newbornscreening@state.mn.us
Website: www.health.state.mn.us/newbornscreening

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