NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

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Commissioner

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Executive Deputy Commissioner

Blood Spot Disposition Form

Although the usage of dried blood spot specimens is highly controlled and confidential, some parents/legal guardians may wish to have their child's specimen(s) excluded from use for anything beyond the routine mandated screening. To have your child's specimen(s) destroyed, or simply excluded from research use, please fill out the form below indicating your wishes. Your request will apply to the baby's initial specimen, as well as any necessary repeat specimens that were submitted.

Child's Name: _____

Child's Date of Birth: _____

Child's Gender: ☐ Male ☐ Female ☐ Unspecified

Child's Hospital of Birth: _____

AKA (Aliases): _____

Mother's Name: _____

Laboratory ID Number (from pink copy): _____

My baby's specimen(s) should be (choose one):

☐ Excluded for all research purposes (specimen will be stored separately) and allowed only under certain circumstances (after your written parental approval).

☐ Destroyed after the completion of Newborn Screening and your baby reaches 8 weeks of age.

Please note: The Program will not return specimens to parents/legal guardians. These specimens, once destroyed, will also not be available in the future should the need for further clinical or identification testing arise.

_____ _____
(Print Mother/Legal Guardian's Name) (Date) (Print Father/Legal Guardian's Name) (Date)

_____ _____
(Signature - Mother/Legal Guardian) (Signature - Father/Legal Guardian)

Address (confirmation letter will be sent here):

_____

_____

Phone Number and Email: _____

Mail completed form to: Director, Newborn Screening Program, Wadsworth Center, 120 New Scotland Avenue, Albany, NY 12208, **Email to:** nbsinfo@health.ny.gov or **Fax to**: 518-474-0405