NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

Parent/Individual Consent and Authorization for Newborn Screening Results

Child's Full Name: _____ Child's Date of Birth: _____

Twin/Multiple? □ Yes □ No

Mother's Current Full Name: _____ If Yes, birth order: _____

Example: Twin B

Mother's Maiden Name/Name at Time of Child's Birth: _____

Child's Hospital of Birth (in NYS): _____ Lab ID #: _____

(if known)

Method of Delivery (select one):

Please note: test reports cannot be sent via email but may be sent via fax OR mail.

□ **Fax:**

Fax number where results are to be sent: _____ (ex.: fax # for College Athletic Office)

To whose attention should the fax be sent? _____

Phone number for receiver if fax fails: _____

□ **Mail:**

Name and mailing address where results are to be sent via the US Postal Service:

_____

_____

_____

Signature:

_____ _____

Signature of individual if 18 years or older Date

_____

Signature of parent/guardian if child is less than 18

_____ _____

Printed name/relationship Phone # (if questions)

Send your request via <u>one</u> of these methods:

Mail: Newborn Screening Program, 120 New Scotland Ave., Albany, NY 12208
Fax: 518-474-0405
Email: nbsinfo@health.ny.gov