ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

Parent/Individual Consent and Authorization for Newborn Screening Results

Child's Name: ________________________________ Child's Date of Birth:_________________

Mother's Name: _______________________________ Gender: ☐ Male ☐ Female

Child's Hospital of Birth: ____________________ Lab ID Number:_____________________

Name and Address where results are to be sent:

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Fax number where results are to be sent: ________________________

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Signature of Individual if 18 years of age or older Date:

____

Phone Number

Send your request:

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