



KATHY HOCHUL  
Governor

MARY T. BASSETT, M.D., M.P.H.  
Commissioner

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Acting 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:**

- Excluded for all research purposes (specimen will be stored separately)
- 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