KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
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: ______________________

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