



Child's name (first & last):

Birth date:

Birth mother's name (first & last):

Hospital or place of birth:

This form applies to: *(Please check all that apply)*

Blood spot specimen(s) All test results (blood spot, hearing, & pulse oximetry)

Parent(s) or guardian(s): please read and understand the following before completing and signing this form.

I, the parent or guardian of the child named below, am directing the Minnesota Department of Health (MDH) Newborn Screening Program to destroy my child's newborn screening blood spot specimen(s) and/or screening test results, pulse oximetry results, and hearing screening results stored at the Minnesota Department of Health, as specified above.

I understand that destroying my child's blood spot specimen(s) will make them unavailable for any future use. Destroying my child's test results stored at the Minnesota Department of Health will limit future access to them by my family and health care providers.

Parent or guardian printed name (first & last):

Parent or guardian signature:

Today's date:

Relationship to child:

Mailing Address

Address line 1:

Street address, company name, c/o

Address line 2:

Apartment, suite, unit, building, floor, etc. - MDH cannot ship to a P.O. box

City:

State/Province/Region:

ZIP/Postal code:

Phone number:

*Due to the Clinical Laboratory Improvement Amendments (CLIA) - regulations responsible for governing lab testing - the Minnesota Department of Health is required to keep test results for two years. You will be notified by MDH via US mail upon destruction of dried blood spots as well as the date when the test results will be destroyed.

Send completed form to:
Minnesota Department of Health
Newborn Screening Program
P.O. Box 64899
St. Paul, MN 55164-0899

Phone: (800) 664-7772
Fax: (651) 215-6285
Email: health.newbornscreening@state.mn.us
Website: www.health.state.mn.us/newbornscreening