



State of California—Health and Human Services Agency
California Department of Public Health



RON CHAPMAN, MD, MPH
Director & State Health Officer

EDMUND G. BROWN JR.
Governor

CONSENT FOR DISCLOSURE AND/OR RELEASE OF CONFIDENTIAL INFORMATION FROM GDSP

The undersigned hereby authorizes the release of Newborn Screening Test Results from the records of the Genetic Disease Screening Program. Fax completed form to: (510) 412-1559 or mail completed form to: Attention: NBS Results, Genetic Disease Screening Program, 850 Marina Bay Parkway, F175 Mail Stop 8200, Richmond, CA 94804

REQUESTING NEWBORN SCREENING RESULTS FOR:

Name:
Gender: Male Female Date of Birth:
Hospital Of Birth:
Home Address on Date of Birth:
Mother's Full Name:
Mother's Last Name on Date of Birth:
Mother's Date of Birth:

RELEASE RECORDS TO:

Name:
Address:
Phone: Fax #:

This authorization will expire on (Enter Date):

You have the right to retain a copy of this consent. You have the right to revoke this consent at any time by writing to Chief, Genetic Disease Screening Program at the address above as stated in our privacy notice. Revocation of this consent does not eliminate your responsibilities for payment for services received. The Genetic Disease Screening Program is not responsible for further disclosures of the information by other parties that may result from complying with this consent.

Signature Printed Name

(Parent or Legal Guardian should sign only if request is for a minor under 18 years of age)

Date signed: Home phone: Work phone:

I understand that any person who requests or obtains any record containing personal information from the California Department of Public Health under false pretenses will be guilty of a misdemeanor and fined up to \$5,000 or imprisoned up to one year or both. PLEASE SEE PRIVACY NOTIFICATION ON REVERSE