State of California—Health and Human Services Agency

California Department of Public Health

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 go to our website (see below) for our **Notice of Information & Privacy Practices**