

**Florida Department of Health
Newborn Screening Program
RELEASE OF NEWBORN SCREENING RESULTS**

See reverse side of form for instructions.

In order to assure patient identification in compliance with the Health Insurance Portability and Accountability Act (HIPAA), the Newborn Screening (NBS) Program requires the completion of the following information:

Patient Name		
Date of Birth		
Street Address		
City, State, Zip		
Provider		
Type of Test(s)		
Name of physician office or health department where test was collected:		
Date(s) when test was collected:		
I understand that this request is valid for the patient listed above and all results documented on this request will be released to the person signing this document. I understand FLBPHL records will contain personal healthcare information and when released FLBPHL is not liable for distribution beyond this signed request. If this document is not signed FLBPHL will not be able to process the request and results will not be provided.		
Signature		Date:
If parent, guardian, or personal representative: print your name and relationship:		

Send results by Mail Fax Fax # _____ Phone # _____

Name and address information if report is to be sent to an alternate address:

Name Address City, State, Zip	FOR NBS Program STAFF ONLY: Received ___/___/___
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INSTRUCTIONS FOR REQUESTING COMPLETED PATIENT TEST RESULTS

Newborn screening results are issued only to the newborn's parent or legal guardian, the person on whom testing was performed, the newborn's legal representative, or a person designated by the newborn's parent or legal guardian. The NBS Program reserves the right to contact the ordering provider/submitter as needed to verify the authority and identity of the person requesting the laboratory test result.

The NBS Program has up to 30 days from the time the request has been received to provide laboratory test results.

THE LABORATORY IS NOT RESPONSIBLE FOR INTERPRETING LABORATORY TEST RESULTS. If you have questions about the results, contact your medical provider.

In order to provide your results, we must verify your identity to ensure that we are not violating State and Federal privacy laws.

1. Submit a copy of one of the following identification documents with this completed form:

- Driver's license
- ID card issued by federal, state, or local government
- Passport
- School ID card with photograph
- Original or certified birth certificate

2. If you are the parent or guardian of a newborn for whom you are requesting the newborn screen result, please provide a copy of the newborn's birth certificate or proof of adoption or guardianship in addition to your identification documentation.

3. If you are the legal representative of the patient, please submit documentation proving your legal authority to request this information (for example: power of attorney, health care surrogate form, order of appointment of guardianship, order appointing personal representative, letters of administration).

Mail the completed form and copy of identification to:

Florida Newborn Screening Follow-Up Program
Division of Children's Medical Services
Florida Department of Health
4052 Bald Cypress Way, Bin A-06
Tallahassee, Florida 32399-1707

Or Fax to:

(850) 922-5385, Attention: NBS Program

If you have questions, call (850) 245-4201