



**Commonwealth of Pennsylvania, Department of Health**

**Authorization to Obtain Newborn Screening Results and for Disclosure of Protected Health Information**

**The DEPARTMENT OF HEALTH may take up to three business days to fulfill the request.**

**1. I authorize the Pennsylvania Department of Health (Department) to use/disclose individual newborn screening information/results obtained from the records of: (Please Print)**

Name at Birth: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M F

Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Hospital of Birth: \_\_\_\_\_

Mother's Full Name: \_\_\_\_\_

Mother's Maiden Name: \_\_\_\_\_

Last 4 digits of Mother's Social Security Number: \_\_\_\_\_

**2. Reason for disclosure of Department Newborn Screening Results:(Describe each specific purpose – such as: use for direct patient care or college application)**

\_\_\_\_\_

**3. I understand that:**

- a. This authorization may be revoked at any time by writing to the Department except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.
- b. The Department will not condition treatment, payment, enrollment or eligibility on the provision of this authorization.
- c. Information disclosed pursuant to this authorization may be subject to re-disclosure by the organization identified in section below and is no longer protected by federal privacy regulations.
- d. The Department, its programs, services, employees, officers, and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.
- e. I may refuse to sign this authorization.

**4. This information is to be disclosed to:**

Name or title of the organization: \_\_\_\_\_

Fax number where results will be sent: \_\_\_\_\_

**5. This authorization expires when results have been obtained.**

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\_\_\_\_\_  
Signature of Parent/Guardian, Individual or Personal Representative Date

If personal representative, state relationship to individual: \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness Date

\_\_\_\_\_  
If individual is physically unable to sign, signature of second witness Date