Commonwealth of Pennsylvania, Department of Health
Authorization to Obtain Newborn Screening Results and for Disclosure of Protected Health Information
It may take up to five business days to fulfill the request.
Completed request forms can be submitted to the Pennsylvania Department of Health at fax 717-724-6995 or emailed to RA-TCNBSAdmin_Fax@pa.gov

1. **I authorize the Pennsylvania Department of Health (Department) to disclose individual newborn screening information/results obtained from the records of: (Please print.)**
   Name at birth: _____
   Date of birth: _____ Sex: M F If multiple birth: A B C D
   Address: _____
   Telephone: _____ Hospital of birth: _____
   Mother's full name at time of delivery: _____
   Mother's maiden name: _____ Mother's date of birth: _____
2. **Type of Newborn Screening Results Requested and Reason for Disclosure:** (dried blood spot test results, critical congenital heart defect screening results, and/or hearing screening results).

   _____

3. **List the specific purpose for each result requested:** (such as: use for direct patient care*, early intervention services, or college application)

   _____

   This information is to be disclosed to:

   Name of individual or title of the organization:_____

   Fax number and/or email address where results are to be sent:_____

   *Hospitals and primary care providers in Pennsylvania must obtain all screening results from nbs.pa.gov

4. **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, revocation will only prevent future disclosure.

   b. Treatment, payment, enrollment, or eligibility is not conditioned on the provision of this authorization.

   c. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient identified in this Authorization. and may 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.

5. **This authorization expires once the results have been received by the above individual or organization.**

_____Date: _____
Signature of parent/guardian, individual or personal representative. If personal representative, state relationship

_____
Printed name

For questions on form completion please call 717-783-8143 or email RA-TCNBSAdmin_Fax@pa.gov