NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

Parent/Individual Consent and Authorization for Newborn Screening Results

Child's Name: _____ Child's Date of Birth: _____

Mother's Name: _____ Child's Sex at Birth: □ Male □ Female □ Unspecified

Child's Hospital of Birth: _____ Lab ID #: _____

Please note: test reports cannot be sent via email but may be sent via mail or fax.

Name and mailing address where results are to be sent:

_____

_____

_____

Fax number where results are to be sent (if applicable): _____

_____ _____
Signature of individual if 18 years of older Date

_____
Signature of parent/guardian if child is less than 18

_____ _____
Printed name/relationship Phone # (if questions)

Send your request:

Mail: Newborn Screening Program, 120 New Scotland Ave., Albany, NY 12208
Fax: 518-474-0405
Email: nbsinfo@health.ny.gov