VERMONT
DEPARTMENT OF HEALTH
healthvermont.gov

NEWBORN SCREENING (NBS) REQUEST FORM FOR INDIVIDUALS BORN IN VERMONT

IF THE INDIVIDUAL WAS NOT BORN IN VERMONT, PLEASE CONTACT THE NEWBORN SCREENING PROGRAM FOR THE STATE IN WHICH THE INDIVIDUAL WAS BORN

Newborn screening provides information about a newborn's risk of having a congenital or inherited condition. Newborn screening does not provide diagnostic testing, and newborn screening results are not confirmation of a congenital or inherited condition. If there are clinical concerns for a screened condition, or known family history, we recommend the individual work with their provider to obtain a diagnostic test and appropriate counseling regarding the results. By requesting these results, the individual below acknowledges the risk in relying on newborn screening results as a means of verifying their (or their child's) health status. If results are requested by email, the requester understands that the State of Vermont cannot guarantee the security of email transmissions of Protected Health Information (PHI).

FAX ALL REQUESTS TO 802-951-1218

SECTION I (*please print*)

Patient name: _____ Birth order (if a twin/multiple birth): _____

Parent/guardian full name (or birth parent's name if different than legal parent/guardian):

_____

Date of birth: _____ Hospital of birth: _____

_____

Please fax screening report to: ☐ Individual ☐ Parent/Guardian ☐ Health care provider ☐ Organization listed in Section III

Please send report to fax #: _____

Phone # for follow up questions: _____

STOP HERE IF YOU ARE REQUESTING YOUR OWN OR YOUR CHILD'S NBS REPORT

Health Care Providers: By making this request, you certify that you are the current health care provider for the patient below.

Practice name: _____ Attn: _____

STOP HERE IF YOU ARE A PROVIDER REQUESTING A PATIENT'S NBS REPORT

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Sections II-VI must be completed if report is to be sent to a party other than the individual or a health care provider

Individuals who want the **Vermont Newborn Screening Program** to share information about them (or their minor child) with another person or organization must fill out all the sections below and fax both pages of this release form. If any sections are left blank, the permission will not be valid, and we will not be able to share information with the person(s) or organization(s) listed.

SECTION II (*please print individual's name)*

I, _____, give my permission to The Vermont Newborn Screening Program of the Vermont Department of Health, 280 State Dr., Waterbury, VT. 05671-8360, Phone: 802-951-5180 and Fax: 802-951-1218, to share my newborn screening results, or the newborn screening results of my child (if under 18) with the person(s) or organization(s) that I list in Section III below.

SECTION III – Who may receive my information

The Vermont Newborn Screening Program may share **my newborn screening results (or my child's screening results if under 18)** with the following person(s) or organization(s). If more than one, list information for all recipients:

Person(s): _____

Organization(s): _____

Address: _____

Fax: _____ Phone: _____

I understand that the person(s) or organization listed in this section may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them.

SECTION IV –Signature **Please sign and date this form and print your name.**

_____ _____

Individual's signature **Date**

_____

Print individual's name (First, last)

If this form is being filled out by someone who has the legal authority to act for the individual (such as the parent of a minor child, a court appointed guardian or executor, or health care agent), please

Print the name of the person filling out this form: _____

Signature of the person filling out this form: _____

Relationship to the individual: _____

Please provide any documents setting forth the legal authority, i.e. copy of an official birth certificate, court order, etc.

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SECTION V – Reason for sharing this information:

_____

SECTION VI – How long this authorization lasts

This authorization to share my information will expire (indicate date):

If I do not list a date, this authorization will expire one year from the date it is signed. I understand that I can change my mind and withdraw this authorization at any time. To do this, I need to submit my withdrawal in writing to: **The Vermont Newborn Screening Program of the Vermont Department of Health, 280 State Dr., Waterbury, VT. 05671-8360, Phone: 802-951-5180 and Fax: 802-951-1218.** If my information has already been lawfully shared by the Vermont Newborn Screening Program, I understand that I can only withdraw my authorization for any future disclosures.