SICKLE CELL 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

The NCAA, U.S. Military, and other entities require those participating in strenuous activities to provide proof of their sickle cell trait status. Newborn screening provides information about the 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. Newborn screening is not intended to provide information about an adult's risk for a condition. We instead recommend the individual work with their provider to obtain a diagnostic test and receive 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 sickle cell 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*)

Student/individual's 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 sickle cell screening results to: [ ] Individual [ ] Parent [ ] 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 this individual.

Practice name: ____ Attn: ______________________________

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

Sections II-VI must be completed if report is to be sent to a party other than the individual or 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) you listed on this form.

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 only my newborn sickle cell screening results, or the sickle cell results of my child (if under 18) with the person(s) or organization that I list in Section III below.

SECTION III – Who may receive my information

The Vermont Newborn Screening Program may share **my newborn sickle cell screening results (or my child's results if under 18)** with the following person(s) or organization. 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, for example copies of an official birth certificate.

SECTION V – Reason for sharing this information:

Participation in athletics: _______ Other: _________

SECTION VI – How long this permission 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.** <u>If the 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.</u>