



STATE OF WASHINGTON
DEPARTMENT OF HEALTH
OFFICE OF NEWBORN SCREENING

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AUTHORIZATION TO DISCLOSE NEWBORN SICKLE CELL SCREENING RESULTS

I, _____, do hereby authorize the Washington State Department of Health Newborn Screening Program to disclose the results of newborn sickle cell (hemoglobin) screening for the individual identified in Section 1 below to the individual or institution identified in Section 2 below. This authorization is limited to the disclosure of the results of newborn sickle cell (hemoglobin) screening for this single purpose and expires thereafter.

1. Individual whose newborn sickle cell screening results are to be released:

Name: _____

Date of Birth: _____

Place of Birth: _____
(Hospital or facility name) (City)

Mother's Name: _____
(At time of birth)

2. Individual or Institution to whom results are to be released:

Name: _____

Address: _____

City, State, and Zip Code: _____

Home phone: _____ Cell: _____

E-mail: _____

Signature: _____ Date: _____

Name: _____

Relationship to patient: _____