Directive to Destroy Newborn Screening Test Results and/or Blood Sample

Name of Child:____ Date of birth: __________________________

Hospital of Birth: ____

By signing below, I agree that:

I understand that destroying this blood sample will make it unavailable for any future medical or identification use.

I understand that destroying the Minnesota Department of Health's copy of these newborn screening test results will make them unavailable from the Minnesota Department of Health and that my child's primary care provider and I will hold the only copies of the results.

I understand that destroying the Minnesota Department of Health copy of my child's newborn blood screening test results may limit future access to them by physicians and may necessitate duplicative testing.

(Parent or guardian: Check the box or boxes below indicating your directive.)

☐ Destroy my child's newborn screening blood sample or samples.

☐ Destroy my child's newborn blood screening test results stored at the Minnesota Department of Health.

☐ Destroy my child's newborn hearing screening test results stored at the Minnesota Department of Health.

Parent or guardian signature: ____ Parent or guardian printed name: ________________________

Relationship to child: ____ Date: ____

Address: ____ City: ______________________ Zip: ______________ Phone: ______________

The parent or guardian's identity must be authenticated. This can be done by having either a notary public or a public health or medical professional sign below as a witness.

Witness signature: ____ Witness phone: ___________________________

Witness printed name and position: ____

Send completed form to:

Minnesota Department of Health
Newborn Screening Program
P.O. Box 64899
St. Paul, MN 55164-0899

Phone: (800) 664-7772
Fax: (651) 201-5471
E-mail: newbornscreening@health.state.mn.us
Website: www.health.state.mn.us/newbornscreening