Directive to Destroy Newborn Screening Test Results for and/or Blood Samples from Adults Tested as Minors

Name: ____ Date of birth: __________________

Hospital of Birth: ____

By signing below, I agree that:

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

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

☐ Destroy my newborn screening blood sample or samples.

☐ Destroy my 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.

Signature: ____

Printed name: ____ Date: ______________________

Address: _________________________ City: _____________ Zip: ________ Phone: __________

The identity of the person signing this form 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