PARENT/GUARDIAN REQUEST FOR RELEASE OR DESTRUCTION OF NEWBORN SCREENING BLOOD SPOT CARD(S) OR OPTING OUT OF SECONDARY USES

Please complete all 3 pages of this form and print clearly. Mail the original copy of the form to Newborn Screening Ontario, 415 Smyth Road, Ottawa ON, K1H 8M8.

1. Patient Information

- Child's Name at birth:_____
- Date of Birth (dd/mm/yyyy): ____/___/_____
- Health Card Number:_____
- Mother's Name (at time of child's birth): _____

2. Authorization for Release/Destruction of Blood Spot Card(s):

I. Parent/Guardian Information:

☐ Check here if you are the sole guardian for the child indicated above

_____ _____
Last name First name

_____ _____ _____
Signature Date (dd/mm/yyyy) Location

☐ **I warrant that the above information is true and accurate.**

II. Additional Parent/Guardian Information:

_____ _____
Last name First name

_____ _____ _____
Signature Date (dd/mm/yyyy) Location

☐ **I warrant that the above information is true and accurate.**

III. Primary Care Provider Attestation:

This form must be signed by your Primary Care Provider who can attest to your identity and guardianship of the child.

I, _____ (first and last name) have reviewed this information and confirm to the best of my knowledge that the above parents/guardians identities have been validated and are the parents/guardians of the child in question.

Signed: _____Dated: _____

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Please initial each paragraph to confirm that it has been reviewed and understood.

In most cases the newborn screening blood spot cards are stored as part of the child's medical record until the child is 19 years of age, at which point they are securely destroyed. The full reasons why blood samples are stored are outlined on our website. These include retesting or release of the sample at the request of the parent/guardian or the child's health care provider (for example health-related testing to help make a diagnosis). Storing the sample means it is available if needed. By releasing/destroying the sample, NSO can no longer provide further testing of the sample if it is deemed necessary in the future.
Parent/Guardian Initial:_____
Additional Parent/Guardian Initial: _____

NSO recommends that samples are stored until a child is five years of age. If your child is under the age of five and you still wish for destruction or release of the sample(s), this request will be honoured.
Parent/Guardian Initial: _____
Additional Parent/Guardian Initial: _____

In general, information that can connect a baby to the blood spot sample can only be shared if you okay it in writing or if it is required by law. It is possible to opt out of secondary uses but have the blood spot sample remain at NSO. To opt out of secondary uses without releasing or destroying the sample, please contact NSO by phone or email.
Parent/Guardian Initial:_____
Additional Parent/Guardian Initial: _____

For samples being sent, at the parent/guardian's request, to a Health Care Provider or Researcher for secondary use it is recommended that only part of the blood spot sample be sent, with the remainder of the sample retained by NSO when possible. Retaining a portion of the sample ensures its availability for any additional testing that may be required in the future.
Parent/Guardian Initial:_____
Additional Parent/Guardian Initial: _____

IV. Request:

☐ **I/We wish to have our child's newborn screening blood spot card(s) DESTROYED**

☐ **I/We wish to have our child's newborn screening blood spot card(s) RELEASED TO US**

Parent/Guardian Initial: _____
Additional Parent/Guardian Initial: _____
Primary Care Provider Initial: _____

3. Parent/Guardian Address and Contact Information

(Address to which blood spot card(s) will be sent OR confirmation of sample destruction will be sent)

_____ _____ _____
Street Number Street name Unit number

_____ _____ _____
City Province Postal Code

_____
Phone Number

FOR NSO USE ONLY

I. Specimen Information:

	Accession Number	Date of Collection (dd/mm/yyyy)	Submitting Hospital / Midwifery Practice / HCP
1			
2			
3			

II. Specimen barcode(s) confirmed by:

_____ _____ _____
Signature Print Name Date(dd/mm/yyyy)

The above specimen(s) was/were: □ **Released** □ **Destroyed by:**

_____ _____ _____
Signature Print Name Date(dd/mm/yyyy)

III. Approval provided by (*specimen destruction or release requires the approval of the Executive Director):

_____ _____ _____
Signature Print Name Date(dd/mm/yyyy)