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

Please complete this form and print clearly.

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: _____

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: _____

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 destruction or release of the sample(s), this request will be honoured.

Parent/Guardian Initial: _____

Additional Parent/Guardian Initial: _____

Primary Care Provider Initial: _____

3. Parent/Guardian Address and Contact Information

(Address to which blood dot 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)