State of Illinois
Illinois Department of Public Health

Parent/Individual Consent and Authorization to Release Newborn Hearing Screening Results

The following information is required in order to release newborn hearing screening results (Note this form must be notarized):

Child's Name _____ Mother's Name at Birth _____

Child's Date of Birth _____ Gender _____ Birth Hospital _____

How would you like to receive this information: ❑ Mail ❑ Fax ❑ Electronic

Address/e-mail where results are to be sent:

Fax number where results are to be sent: _____

Phone number where you can be reached: _____

Send this form to:
Illinois Department of Public Health
Newborn Screening Program
535 W. Jefferson St., 2nd Floor
Springfield, IL 62761
Phone: 217-785-8101
Fax: 217-557-5396
DPH.newbornscreening@Illinois.gov

The purpose of the Illinois Department of Public Health Newborn Screening Program is to identify infants at risk for certain congenital conditions and in need of more definitive testing. Newborn screening test results are insufficient information on which to base diagnosis or treatment.

I hereby give permission to the Illinois Department of Public Health Newborn Screening Program to release the newborn hearing screening record of the child identified above.

_____ _____
Signature of Parent or Guardian if child is less than 18 years of age Date

_____ _____
Signature of Individual if 18 years of age or older Date

State of Illinois
County of _____

Signed (or subscribed or attested) before me on _____ (date) by

_____ (name of person).

(Seal)

_____
Signature of notary public