State of Illinois
Illinois Department of Public Health

Health Care Provider Consent and Authorization to Release Newborn Screening Results

❑ Newborn Blood Spot Metabolic Result Requested ❑ Newborn Hearing Screening Result Requested

The following information is required in order to release newborn screening results:

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

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

Medical provider requesting newborn screening results _____

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. As with any laboratory test, false positive or false negative results are possible. Newborn screening test results are insufficient information on which to base diagnosis or treatment.

I certify the child listed above is my patient and hereby grant permission to the Illinois Department of Public Health Newborn Screening Program to release the newborn screening record, including laboratory test reports of the child stated above, for diagnosis and treatment purposes only.

_____ _____
Signature of Health Care Provider Date