State of Illinois
Illinois Department of Public Health

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

Include with this request payment of $25 by check or money order payable to Illinois Department of Public Health. **Do not send cash.** Cash payments will be returned and will delay processing your request. Allow 10 business days to process request. ***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

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 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 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

For Internal Use Only

Date Received _____

Check/Money Order # _____

Received by_____/_____