New Jersey Department of Health
Division of Public Health and Environmental Laboratories
Newborn Screening Program

NEWBORN SCREENING SPECIMEN RELEASE REQUEST FORM

Instructions: *Please complete every field on this form. The information requested on this form will be matched against the information provided in the data fields on the newborn's specimen collection form. Provide your mailing or email address for use in the event the Department needs to contact you about this request.*

I hereby authorize the New Jersey Department of Health Newborn Screening (NBS) Laboratory to release a sample of the residual dried blood spot specimen from my child's newborn screening request form to:

Name of Health Care Provider, Clinical Laboratory or Researcher	
Address	

Child's Last Name		Date of Birth		Sex	☐ Male ☐ Female
Mother's First and Last Name				Mother's Zip Code	
Name and Location of Birth Hospital					
Newborn Screening Request Form Number (8 digit number in red located at top of parent copy) (if known)					

Relationship to Child	☐ Parent ☐ Legal Guardian*	Print Name	
Current Mailing Address or Email Address of Parent / Legal Guardian			
Date		Parent / Legal Guardian*	(signature)

***If legal guardian, please provide photocopy of letters or order of guardianship.**

The completed form can be submitted by fax to 609-530-8373, emailed to NJNBS.Results@doh.nj.gov, or mailed to Newborn Screening Laboratory, PO Box 371, Trenton, NJ 08625-0371.

All release requests will be handled in accordance with Department policies.