GEORGIA DEPARTMENT OF PUBLIC HEALTH

Newborn Screening Report Form

Authorization for Release of Newborn Screening Report

Instructions: Complete the form and fax to the Georgia Newborn Screening Program at (404) 657-2773 or email to dph-nbs@dph.ga.gov. Proof of identity must be provided (e.g., driver's license).

Child's Name: (Last)	(First)	**Child's Date of Birth:**	**Gender:** ☐ Male ☐ Female ☐ Other
Address:			
City:	**State:**	**Zip:**	**Birth Facility Name:**
Mother's Name at Delivery: (Last)	(Maiden)	(First)	**Mother's Date of Birth:**

AUTHORIZATION FOR RELEASE OF NEWBORN SCREENING REPORT

1. I hereby voluntarily authorize the Georgia Department of Public Health (DPH) to disclose the requested medical information to:	Name of Person/Facility: Phone: Fax:
2. The purpose for this disclosure is for:	☐ Continued patient care ☐ Personal Record ☐ Insurance ☐ Sport Requirement ☐ Other:
3. The information to be disclosed includes:	☐ Newborn Screening Report ☐ Follow-up Notes ☐ Other (specify):
4. This authorization shall become effective immediately and shall remain in effect until the specified authorization end date or for one year from the date of signature if no date is entered:	Authorization End Date: (MM/DD/YYYY)

Initial:	I understand that I may revoke this authorization in writing at any time prior to the release of information from DPH, and that revocation will not affect any action taken in reliance on this authorization before the written revocation was received.
Initial:	I understand that my eligibility for benefits, treatment, or payment is not conditioned upon the provision of this authorization.
Initial:	I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA).

Patient's Printed Name:	**Patient's Signature:**
Date Signed: (MM/DD/YYYY)	
Authorized Guardian or Representative Printed Name:	**Authorized Guardian or Representative Signature:**
Date Signed: (MM/DD/YYYY) **Relationship to Child:**	

Georgia Newborn Screening Program | www.dph.ga.gov/NBS

Print Form