STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

**STATE OF CONNECTICUT**
**DEPARTMENT OF PUBLIC HEALTH**
**AUTHORIZATION TO DISCLOSE NEWBORN SCREENING PROTECTED HEALTH INFORMATION**

**Patient Name**: _____ **Date of Birth**: _____

I authorize the **State of Connecticut, Department of Public Health (DPH)** to disclose the following health information for the individual identified above (check all that apply):

☐ Newborn Screening (NBS) Laboratory Report(s)

☐ A portion of the NBS Dried Bloodspot Sample;

☐ Other (specify)_____

**I authorize DPH to release the information/sample as indicated above to:**

**Name**: _____

**Address**: _____

**City**: _____ **State**: _____ **Zip**: _____

**Phone**: _____ **Fax**: _____ **Email**: _____

**I authorize this disclosure for the following purpose:**

☐ medical ☐ legal ☐ disability ☐ insurance ☐ other (specify):_____

**I authorize the following method(s) of disclosure of this information/sample (check all that apply):**

☐ mail ☐ verbal ☐ pick up ☐ fax ☐ email

**Expiration:** This authorization expires on: _____(specify date or event)

**I understand and agree that:**

1. **I may revoke this request at any time by notifying DPH in writing; however, any revocation will not apply to any information or samples that have already been released.**
2. **Information disclosed under this authorization may be re-disclosed and is no longer protected by privacy regulations.**
3. **DPH will not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization.**
4. **If the patient is a minor (under age 18) or has a legal guardian, the patient's parent or legal guardian must sign this authorization.**
5. **A copy of the patient's or legal representative's photo identification (i.e. driver's license or passport) must accompany this request to verify authority.**

Phone: (860) 920-6628 • Fax: (860) 730-8385
Telecommunications Relay Service 7-1-1
395 West Street
Rocky Hill, Connecticut 06067
www.ct.gov/dph

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6. **All requests must be witnessed and signed.**
7. **Both pages of this form and copy of photo identification must be mailed to QA Manager, Dr. Katherine A. Kelly State Public Health Laboratory, 395 West Street, Rocky Hill, CT 06067 or emailed to dph.nbstracking@ct.gov.**

_____ _____
**Patient or Legal Representative (signature)** **Date**

_____
**Patient or Legal Representative (printed name)**

Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Conservator ☐ Executor of Estate

☐ Power of Attorney ☐ Other, specify: _____

_____ _____
**Witness (signature)** **Date**

_____
**Witness (printed name)**

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