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
REQUEST TO DESTROY OR RETURN NEWBORN DRIED BLOODSPOT SCREENING SAMPLE

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

I request that the State of Connecticut, Department of Public Health (DPH) - check one:

☐ destroy the newborn screening (NBS) dried blood spot sample for the individual identified above - or -
☐ return the NBS blood spot sample for the individual identified above to the following:

Name of person to return the dried blood spot to: _____

Address: _____

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

- **Following the required minimum 6-month retention period, NBS dried blood spot specimens may be destroyed or returned at the request of the patient or patient's legal representative.**
- **The blood spot sample(s) will be mailed to the individual identified above, or destroyed, as requested above.**
- **I understand that I may revoke this request at any time by notifying DPH in writing; however, any revocation will not apply to any samples that have already been destroyed.**
- **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.**
- **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.**
- **All requests must be witnessed and signed.**
- **Mail this form and copy of photo identification to the Quality Assurance Manager, Dr. Katherine A. Kelly State Public Health Laboratory, 395 West Street, Rocky Hill, CT 06067 or email 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)

version 4/2026

PHI DISCLOSURE FOR INTERNAL USE:

Date Request Received:_____

Date Request Approved:_____

Approved by:_____

Date Completed/Sent:_____

Completed by:_____

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