

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)

PHI DISCLOSURE FOR INTERNAL USE:

Date Request Received: _____

Date Request Approved: _____

Approved by: _____

Date Completed/Sent: _____

Completed by: _____

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