

STATE OF WASHINGTON DEPARTMENT OF HEALTH

OFFICE OF NEWBORN SCREENING

1610 NE 150th Street • Shoreline, WA 98155-9701

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TO: Director, Newborn Screening

Ordering Physician Name:

Phone:

Facility:

RE: Release of Information: Newborn Screening Specimen

I hereby request that newborn screening specimen(s) and associated information from the following patient be released for additional testing to the person or institution listed below:

be released for addit	tional testing to the person or ins	titution listed below:		
Patient's Name: Date of Birth: Place of Birth:				
Patient's MRN: Mother's Name: (at time of birth)	(facility name)	(city)		
Reason for testing:	- 			
Person or institution	n to whom specimen should be re	eleased:		
Name:	Seattle Children's Hospital Laboratory			
Address:	4800 Sandpoint Way NE, FB.2.441, Attn: LAB			
	Seattle, WA 98105			
Email address:	LabClientServices@SeattleChildrens.org			
Phone:	Phone: 206-987-2102	Fax: 206-987-1465		
Affiliation:				
Health Care Information under the provisions of my signature below. I am the parent or other representative of the pat	n Act, Chapter 70.02 Revised Code of V RCW 70.02.030 (Patient authorization wise authorized to consent to health car	investigation or other purposes as authorized under the Uniform Washington (RCW). I understand that if this release is authorized of disclosure) my consent to access expires 90 days from the date of the for this patient; or, if the patient is deceased, I am a personal presentative of deceased patient or otherwise authorized to receive thout patient's authorization.		
I declare under pend	alty of perjury under the laws of the	State of Washington that the foregoing is true and correct		
(Print Name)	(Relationship to Patient)			
(Signature)		(Date)		

For Internal Use Only:

	Date	Staff initials
Request Received:		
Specimen Released:		