STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
BUREAU OF FAMILY HEALTH AND NUTRITION
MATERNAL AND CHILD HEALTH SECTION

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Fax: 603-271-4519 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

NH Newborn Screening Report Request Form

Please be sure **ALL FIELDS** are filled in before faxing your request

PATIENT INFORMATION

Patient name	First Name:	Last Name:
Patient date of birth		Sex (select one) F M
Birth facility and city		
Mother's name at time of patient's birth	First Name:	Last Name:

PROVIDER INFORMATION

Requestor's name	First Name:	Last Name:
Facility name and city		
Health care provider's name	First Name:	Last Name & Credential (MD, NP etc.):
Direct phone number **(+ extension)** of requestor/provider:		**Fax number** where report is to be sent:

The requested document(s) contains confidential patient health information that is legally privileged. This information is intended only for the use of the individual or entity named above. Any unauthorized review, use, disclosure, or distribution of this communication(s) is expressly prohibited.

I certify the child listed above is my patient and hereby grant permission to the New Hampshire Department of Health and Human Services Newborn Screening Program to release the newborn screening record, including laboratory test reports of the child stated above, for diagnosis and treatment purposes only.

Signature of Health Care Provider

Date

Please return this completed document **with your office fax cover page** to the NH Newborn Screening Program **FAX: 603-271-4519**