Lori A. Weaver
Commissioner

Iain N. Watt
Interim Director

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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AUTHORIZATION FOR RELEASE OF INFORMATION
PERMISSION TO SHARE NEWBORN SICKLE CELL SCREENING RESULTS

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

SECTION I- PATIENT INFORMATION

Patient Name	First:	Last:
Patient Date of Birth		Sex (select one) F M
Birth Facility		
Patient's Mother's Name at Time of Birth	First:	Last:

SECTION II- WHO MAY RECEIVE MY INFORMATION

The New Hampshire Newborn Screening Program may share the newborn sickle cell screening results with the person(s) or organization listed below:

Name:
Organization:
Address:
Fax #
Phone #

I, _____, understand that the person(s) or organization listed in section II
(PRINTED NAME)
(above) may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them. I give my permission to share the patients NEWBORN SICKLE CELL SCREENING RESULTS with the person(s) I list in Section II (above).

_____ _____
Patient/Parent/Legal Agent Signature Date

_____
Printed Name

_____
Identification (if other than patient)