Commonwealth of Virginia
Division of Consolidated Laboratory Services
600 North 5th Street
Richmond, Virginia 23219

Authorization and Consent to Release Medical Records for Newborn Screening Hemoglobinopathy Results

1. Patient Information:

Last Name _____ First Name _____ Middle Name _____ Sex (Circle One) Male Female

Current Address Street _____ Apt.# _____ City _____ State _____ Zip Code _____

Last Name (at birth) _____ First Name (at birth) _____ Middle Name (at birth) _____ Date of Birth _____

Hospital of Birth _____ Physician of Record at Time of Collection _____

Mother's Last Name at Birth _____ First Name _____ Middle Name or Initial _____

Address at Birth Street _____ Apt.# _____ City _____ State _____ Zip Code _____

2. Authorization for Release. I hereby authorize the **Division of Consolidated Laboratory Services, Newborn Screening Laboratory, Richmond, Virginia, 23219**, to release, disclose, and deliver the Hemoglobinopathy Screening results obtained at birth. (Please Note: this request may take up to two weeks to process.)

Authorized Recipient:

_____

_____

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Disclaimer:
Using the standard initial screening methodology of isoelectric focusing (IEF), this laboratory can presumptively identify the following major hemoglobin (Hb) bands: F, A, S, D, C, E, and hemoglobin Bart's. Subsequent HPLC methodology permits quantification of the abnormal Hb variants. Hemoglobin bands other than the ones listed above will be reported as FAV with "V" designating an unidentified band. The normal hemoglobin pattern in a newborn is FA. While the sensitivity of IEF and HPLC are excellent, results and their interpretation can be compromised by extreme prematurity or previous blood transfusions.

3. Specific Authorization. I specifically authorize the release of my Hemoglobinopathy results, obtained at birth as a screening test to the above named recipient.

I do not give permission for any other use or redisclosure of this information.

Date _____ Name (Print) _____ Signature _____

Date _____ Parent/ Guardian Name (Print) (If patient is under 18 years of age) _____ Parent/ Guardian Signature _____

4. **Redisclosure**. This release does not authorize redisclosure of medical information beyond the limits of this consent. The Recipient of this information is prohibited from using the information for other than the stated purpose, and from disclosing it to any other party without further authorization. The following written statement should accompany certain disclosures:

   This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and 45 CFR Parts 160 and 164). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by (42 CFR Part 2 and 45 CFR Parts 160 and 164). A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

   I specifically understand and agree that the REDISCLOSURE requirements set out above will apply to these records.

5. **Validity**. I understand this authorization is a onetime authorization.

   I authorize the release of information as indicated above.

_____

Date Name (Print) Signature

_____

Date Parent/ Guardian Name (Print) Parent/ Guardian Signature
(If patient is under 18 years of age)

Request Must Be Notarized

_____ Notary
Date Signature

_____
Signature

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This area is for Newborn Screening Laboratory's use only:

_____ _____ _____ _____
Date Received Initials Date Processed Initials

Comments: _____

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