

Commonwealth of Virginia
Department of General Services
Division of Consolidated Laboratory Services
Richmond, Virginia

Authorization and Consent Release-Hemoglobinopathy

SECTION 1: Patient Information at the time of testing

(Please print):

_____	_____	_____			
First Name	Last Name	Middle Initial			
Male _____ Female _____	_____	_____			
Sex (Circle one)	Date of Birth	Phone number (XXX-XXX-XXXX)			
_____	_____	_____			
Current Address Street, Apt. #	City	State	Zip Code		
_____	_____	_____	_____		
Hospital of Birth	Physician of Record at the Time of Collection/Concern				
_____	_____	_____	_____		
Mother's Last Name at Birth	First Name	Middle Name or Initial			
_____	_____	_____	_____		
Mother's Address at Birth	Street	Apt. #	City	State	Zip Code

SECTION 2: Authorization of Release:

I hereby authorize the Department of General Services, Division of Consolidated Laboratory Services, Richmond Virginia, 23219, to release, disclose and deliver the result(s) indicated above. **Please be aware this request may take up to thirty days to process and deliver.**

Send report to:

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. The normal hemoglobin pattern in a newborn is FA. Hemoglobin bands other than the ones listed above will be reported as FAV with "V" designating an unidentified band. While the sensitivity of IEF and HPLC are excellent, result and their interpretation can be compromised by extreme prematurity or previous blood transfusions. If further information is required regarding these results, please contact your physician.

Re-disclosure:

This release does not authorize re-disclosure 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. I therefore understand this is a one-time authorization.

SECTION 3: Validity: I authorize the release of information as indicated above

Date Patient Name (*Print*) Signature

Date Parent/Guardian /Power of Attorney (*Print*) Parent/Guardian/Power of Attorney (*Signature*)

SECTION 4:

Given under my hand and seal of office this _____ month, day of _____, _____ (year)

Notary Public's Signature

(Personalized Seal):

If a notary is unavailable, you may send a photocopy of your driver's license as proof of your identity.

This area is for Data Entry/IT Support Group's use only:

Date Received Initials Date Processed Initials

Comments:

Hemoglobinopathy Consent Form