Student Athlete Authorization to Release Newborn Screening Results

Department of Health

The Ohio Department of Health Newborn Screening Program identifies infants at risk for certain congenital conditions that need more diagnostic testing. Newborn screening test results are insufficient information on which to base diagnosis or treatment. As with any laboratory test, false positive or false negative results are possible.

The release of screening results will only be provided to the requestor listed below. These records are being disclosed for the purpose of complying with a request for newborn screening results.

Please note that screening results include results for all disorders on the newborn screening panel at the time of screening and are not limited to sickle cell disease and sickle cell trait screening results. Depending on the year the screening panel was conducted, these records contain results of numerous screenings, including but not limited to conditions listed at: https://odh.ohio.gov/know-ourprograms/Newborn-Screening/Newborn-Screening-Panel.

The student's name included on newborn screening results will reflect the name at the time the blood sample was submitted to the Ohio Department of Health Laboratory.

Directions

- TYPE OR PRINT LEGIBLY AND COMPLETE ALL SECTIONS.
- FORM MUST BE NOTARIZED OR COPY OF UNEXPIRED GOVERNMENT-ISSUED IDENTIFICATION SUBMITTED.
- STUDENTS 18 YEARS OF AGE OR OLDER MUST COMPLETE AUTHORIZATION SECTION.
- STUDENTS UNDER 18 YEARS OF AGE MUST HAVE PARENT OR GUARDIAN COMPLETE AUTHORIZATION SECTION.
- IF SOMEONE OTHER THAN STUDENT IS COMPLETING THE FORM, PROVIDE COPY OF DOCUMENTATION ESTABLISHING LEGAL RELATIONSHIP TO STUDENT (for example, birth certificate, power of attorney, etc.).

Student's Information at Time of Testing

Student's first name	Student's last name
Date of birth (mm/dd/yyyy)	Gender assigned at birth ☐ Male ☐ Female
Are you a twin, triplet, or other multiple birth? ☐ Yes ☐ No	City of birth hospital

Birth Mother's Information

Mother's first name	Mother's last name at time of student's birth

Person Requesting Information

Requestor (select one)
☐ Self/Student (Student must be 18 years of age or older).
☐ Custodial Parent or Legal Guardian (Student must be less than 18 years of age).

If the person requesting the information is someone other than the Student, please submit a copy of documentation establishing the requester's legal relationship to Student (for example, birth certificate, power of attorney, etc.).

Authorization to Disclose

I hereby authorize the Ohio Department of Health, to release the newborn screening results of the child listed above.

This authorization will expire upon the provision of the newborn screening results.

I also understand that I may revoke this authorization, in writing, at any time. I further understand that any action taken by the Ohio Department of Health in accordance with this authorization prior to it being revoked is legal and binding.

I understand that my information may not be protected from re-disclosure of the information unless otherwise provided for by state or federal law.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. I also understand, that if I refused to sign this authorization, the Ohio Department of Health will not release the requested information except as permitted or required by state or federal law.

Signature of Requestor _____

Requestor Printed Name	Date (mm/dd/yyyy)
Email Address of Requestor (Results will be emailed)	Phone Number of Requestor

To be Completed by Notary

State of _____

County of _____

The forgoing document was acknowledged before me this _____ of

_____, 20_____ by _____.

_____

Notary Signature Notary Seal

Mail, email, (ODHLabs@odh.ohio.gov) or FAX (614-644-4648) completed, notarized form (2 pages):

Ohio Newborn Screening Program

Public Health Laboratory

8995 East Main Street, Bldg. 22

Reynoldsburg, Ohio 43068

If a notary is unavailable, you may send a photocopy of one of the following to verify the requester's identify: (1) the requester's unexpired driver's license; or (2) another unexpired government-issued form of identification bearing requester's signature.

- It can take up to 30 days to process your request. If you need your results more quickly, consider having a sickle cell test run by your physician of care.
- Newborn screening results are only available prior to the student's twenty-first birthday.
- Newborn screening results are only available for students born in Ohio.
- Email addresses will be verified prior to the release of newborn screening results.