

## STATE OF WASHINGTON DEPARTMENT OF HEALTH

## OFFICE OF NEWBORN SCREENING

1610 NE 150<sup>th</sup> Street • Shoreline, WA 98155-9701

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**TO: Director, Newborn Screening** 

Facility: \_

**RE: Release of Information: Newborn Screening Specimen** 

I hereby request that newborn screening specimen(s) and associated information from the following patient be released for additional testing to the person or institution listed below:

be released for additio	mar testing to the person of r	iistitution fisted below.			
Patient's Name: Date of Birth: Place of Birth:					
Mother's Name: (at time of birth)	(facility name)	(city)			
Reason for testing: _	Univ of Washington	well measure glycosamir	noglycar	n levels to se	
Person or institution to	it is diagnostic of whom specimen should be	f MPS disorders. released:			
Name: Address:					
Email address: Phone: Affiliation:	Fax:				
of my signature below.  I am the parent or otherwise representative of the patier	se authorized to consent to health	on of disclosure) my consent to access care for this patient; or, if the patient is Representative of deceased patient or owithout patient's authorization.	s deceased,	I am a personal	
I declare under penalty	of perjury under the laws of the	he State of Washington that the for	egoing is t	rue and correct	
(Print Name)		(Relationship to Patient	t)		
(Signature)			(Date)		
Ordering Physician Name	e:	For Inter	For Internal Use Only:  Date Staff initials		
		Request Received:	Date	Stan muais	
Phone:		Specimen Released:			