Michigan Department of Community Health

Directive to Remove Residual Newborn Screening Blood Specimen from Possible Research Uses

Child's Name at Birth:	Date of Birth:
Child's Current Name:	Circle Birth Order if Multiple Birth: 1st 2nd 3rd 4th 5th
Mother's Name at Time of Child's Birth:	Hospital of Birth:

I am a legal representative* of the child named above. By signing below, I hereby request the Michigan Department of Community Health to **not** use my child's (or my own) blood specimen for possible future research after newborn screening is complete. I understand that the specimen will be retained by the laboratory but not used for research of any kind unless directed otherwise in writing by a legal representative.

Signature of parent, guardian, or other legal representative:		Relationship to child:	
Printed name:		Date:	
Street Address:	City:	Zip:	Phone:

* **"Legal representative"** means a parent or guardian of a minor who has authority to act on behalf of the minor, or the individual from whom the specimen was collected if 18 years or older or legally emancipated.

⇨Fax completed form to: (517) 335-9776

OR

⇨Mail to:

Michigan Department of Community Health
Newborn Screening Laboratory Section
3350 N. Martin Luther King, Jr. Blvd.
P.O. Box 30035
Lansing, MI 48909

Authority:	Michigan Public Health Code, Act 368 of 1978	The Michigan Department of Community Health is an equal opportunity employer, services, and program provider

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