



# Directive to Destroy Newborn Screening Test Results and/or Blood Sample

**By signing this form, I understand that I am choosing to have newborn screening for my child, but am requesting the bloodspot and/or test results to be destroyed.**

*(Parent or guardian: Check below the box or boxes that apply.)*

## Directive to destroy newborn screening test results and or bloodspots

- Destroy my child's newborn screening bloodspot(s).
- Destroy my child's newborn bloodspot screening test results stored at the Minnesota Department of Health.
- Destroy my child's newborn hearing screening test results stored at the Minnesota Department of Health.

*(Parent or guardian: Read and initial each statement below.)*

I, the parent or guardian of the infant named below, understand that:

If I choose to have my child screened then have his or her blood sample destroyed, the blood sample will be unavailable for any future medical or forensic identification use. *Initial here:* \_\_\_\_\_

Destroying the Minnesota Department of Health's copy of my child's newborn blood screening test results may limit future access to them by physicians and may necessitate duplicative testing. *Initial here:* \_\_\_\_\_

Name of infant:	Birth date:
Hospital or place of birth:	

Parent or guardian signature: \_\_\_\_\_

Parent or guardian printed name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Date: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Send completed form to:

Minnesota Department of Health  
Newborn Screening Program  
P.O. Box 64899  
St. Paul, MN 55164-0899

Phone: (800) 664-7772  
Fax: (651) 201-5471  
E-mail: [newbornscreening@health.state.mn.us](mailto:newbornscreening@health.state.mn.us)  
Website: [www.health.state.mn.us/newbornscreening](http://www.health.state.mn.us/newbornscreening)