



**PARENT REQUEST TO HAVE
NEWBORN BLOOD SPECIMEN CARD DESTROYED**

*If mother is unable to sign, please enclose child's state-issued birth certificate with official seal.
(It will be returned to parent after it has been reviewed.)*

Parent or Parents Making the Request:

Mother's Full Name
(including maiden name): _____

Mother's Date of Birth: _____

Mother's e-mail address: _____

Father's Name (Last, First): _____

Father's e-mail address: _____

Child's Information:

Newborn's Name (Last, First): _____

Date of Birth (mm/dd/yyyy): _____ Gender: Male Female

Hospital of Birth: _____

Address of child at time of birth: _____

Current Mailing Address:

(if different from above)

Phone: () _____ - _____

I understand that any person who requests or obtains any record containing personal information from the California Department of Public Health under false pretenses will be guilty of a misdemeanor and fined up to \$5,000 or imprisoned up to one year or both.

Mother's Signature: _____ Date: _____

Father's Signature: _____ Date: _____

(Parent or Legal Guardian should sign only if request is for a minor under 18 years of age)

Mail completed form to:

California Biobank Program Coordinator
CDPH – GDSP
850 Marina Bay Pkwy., F175, MS 8200
Richmond, CA 94804
e-mail: CaliforniaBiobank@cdph.ca.gov

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