Newborn Screening in Pennsylvania

We highly suggest **you** request a copy of your newborn screening information/results from your Birth State.

For students born in **PA (*PA Dept of Health*)** you may do so by one of two ways:

1) Phone: 717-783-8143 ; or
2) By **faxing** the following form to 717-724-6995.
   Please use the next two pages of this document if requesting your Newborn Screening Results.

For information regarding Newborn Screening in Pennsylvania you can go to the following website.

PA Newborn Screening & Follow-up Program.

If born outside of PA, check with your Pediatrician or consider getting a new test.

Facsimile Cover Sheet

To Newborn Screening

Company PA Department of Health

Fax (717) 724-6995 **Pages**

Phone (717) 783-8143 **Date**

From: **Name**

Address

Phone:

Comments: Enclosed is my Authorization to Obtain my Newborn Screening Results and disclose those results to my Team Physician at Kutztown University.

Please fax the results of the enclosed request to Sports Medicine Staff, Kutztown University of PA, at (610) 683-4664.

The PHI (Personal Health Information) contained in this FAX is HIGHLY CONFIDENTIAL. It is intended for the exclusive use of the addressee. It is to used only to aid in providing specific healthcare services to this patient. If you have received this communication in error, please immediately notify us by telephone at ________________ _______and destroy the copy in your possession.

Commonwealth of Pennsylvania, Department of Health

Authorization to Obtain Newborn Screening Results and for Disclosure of Protected Health Information

1. **I authorize the Pennsylvania Department of Health (Department) to use/disclose individual newborn screening information/results obtained from the records of: (Please Print)**
   Name at Birth:____
   Date of Birth:__________________________ Sex: M F
   Telephone:__________________________________
   Address:____
   Hospital of Birth:____
   Mother's Full Name:____
   Mother's Maiden Name:____
   Mother's Social Security Number (optional): ___________________________________

2. **Reason for disclosure of Department Newborn Screening Results:**(Describe each specific purpose – such as: use for direct patient care or college application)

   College/University Athletic Physical : **Sport Name:** ______________________________________

3. **I understand that:**

   a. This authorization may be revoked at any time by writing to the Department except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.
   b. The Department will not condition treatment, payment, enrollment or eligibility on the provision of this authorization.
   c. Information disclosed pursuant to this authorization may be subject to re-disclosure by the organization identified in section below and is no longer protected by federal privacy regulations.
   d. The Department, its programs, services, employees, officers, and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.
   e. I may refuse to sign this authorization.

4. **This information is to be disclosed to:**

   Kutztown University Sports Medicine Staff { Fax to: 610-683-4664 }
   (Insert name or title of the organization to whom disclosure is to be made)

5. **This authorization expires when results have been obtained.**

****

____
Signature of Parent/Guardian, Individual or Personal Representative Date

If personal representative, state relationship to individual: _____________________________________

____
Signature of Witness Date

____
If individual is physically unable to sign, signature of second witness Date