



Authorization to Release Information Relative to Newborn Screening for Inborn Metabolic Errors and Hemoglobinopathies

Please check all boxes that apply.

- A. I agree that information about _____, born _____, obtained as a result of tests conducted for screening for inborn metabolic errors and hemoglobinopathies may be released or exchanged with the following:

- B. In cases where this information is immediately needed for continuity of health care, I authorize the South Carolina Department of Public Health to provide this information to the providers listed above by fax.
- C. I authorize my signed form to be faxed to the providers listed above.

I understand that my confidentiality cannot be guaranteed when sending this information by fax. I understand that the copy of my signature below may be treated as an original signature.

I am the client, parent or legal guardian. I understand that I am responsible for this information if it is released to me and that my records are protected generally under state laws as well as statutes governing specific types of information and cannot be disclosed without my authorization. I also understand that I may revoke this authorization at any time except to the extent that action has been taken on it.

Signature: _____ Date: _____

Witness: _____ Date: _____

Revoked: _____ Date: _____

Some babies are born with diseases of the blood or body function. A baby with one of these diseases looks healthy. However, these diseases can cause mental retardation, abnormal growth, infections, or death. Some of these diseases can be found by early testing. This testing, called newborn screening, is important so that your baby is not harmed by one of these diseases. During newborn screening, a small sample of your baby's blood is taken from the heel. The blood is tested. The blood shows if your baby has any of the "newborn screening" diseases. If your baby has one of these diseases, your doctor can treat your baby.

DPH can store your baby's blood sample for special study. Studies help DPH find out new information about diseases. If a study finds something in your child's blood sample that can help your child, DPH can confidentially notify you (or your child if he/she is 18 years or older).

White copy – central office, Yellow copy - record where form was signed, Pink – client, parent, guardian

Instructions for Completing 1878-ENG-DPH

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Inborn Metabolic Errors and Hemoglobinopathies**

PURPOSE: The Information Release Form is used to designate to whom information obtained as a result of newborn screening for inborn metabolic errors and hemoglobinopathies may be released. Health department and other health care provider staff will use it. This form is a legislative mandate of Section 44-37-30, South Carolina Code of Laws.

ITEM BY ITEM INSTRUCTIONS:

Section A: Print the name and birth date of the person about whom information is being released in the appropriate spaces. Print the names and addresses of the persons to whom the information is being released or exchanged in the appropriate spaces. Check the box if it applies.

Section B: Check the box if it applies.

Section C: Check the box if it applies.

Signature: The client, parent or guardian signs his/her name and indicates the date in the appropriate space.

Witness: The witness to the signature signs his/her name and indicates the date in the appropriate space.

Revoked: The client, parent or guardian signs his/her name and indicates the date in the appropriate space.

OFFICE MECHANICS AND FILING: Mail the original to: Newborn Screening Follow-up Program, Division of Women and Children's Services, SC DPH, Mills/Jarrett Complex, Box 101106, Columbia, SC 29211. One copy can be given to the client, parent or guardian. One copy is filed under consents at the health department/facility where the form was signed. The form should be retained according to the medical records retention schedule.