Michigan Department of Community Health

Directive to Destroy Residual Newborn Screening Blood Specimen

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 destroy my child's (or my own) blood specimen after newborn screening has been completed. I understand that by destroying this blood specimen, it will NOT be available for any future use including medical, identification, or research purposes.

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.

The identity of the person(s) signing this form must be authenticated. Please attach a copy of:
1) the child's birth certificate and **2) driver's license, state-issued identification card, or passport** of person(s) who signed above. Additional identifying documents may be requested.

⇨Mail completed form with required copies to:

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

Please state why you are making this request. (*This will help improve the newborn screening program, but you do not have to complete this section.*)

☐ Privacy concerns ☐ Not comfortable with research ☐ Other:__________________

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