APPENDIX D

MISSISSIPPI STATE DEPARTMENT OF HEALTH

**REQUEST FOR NEWBORN SCREENING RESULTS / DRIED BLOOD SPOT CARD**

Phone (601) 576-7619 Fax (601) 576-7498

**PLEASE PRINT LEGIBLY.**
**ILLEGIBLE AND INCOMPLETE REQUEST WILL BE RETURNED TO SENDER.**

**TYPE OF REQUEST:**

☐ Newborn Screening Results ☐ Dried Blood Spot Card

**REASON FOR REQUEST:**

☐ Parent Request ☐ Recent Death

☐ Primary Care Provider/Pediatrician ☐ Other: _____

☐ Family History

**REQUESTOR'S REQUIRED INFORMATION**

Name of Facility: _____ Date: _____

Contact Person: _____ Requestor Name: _____

Facility Address: _____

Telephone ( ) _____Fax # ( ) _____

Child's Name (at birth) _____

Last First Middle Initial

Child's Date of Birth: _____ Sex: Male Female Indeterminate (Circle One)

Mother's Name: _____

Mother's Address: _____

Mother's DOB: _____

County of residence at birth: _____

If child has a different last name than above please list below:

---

**CONFIDENTIALITY NOTE: This information has been disclosed to you from records whose confidentiality is protected. Statutes/Regulations prohibit you from making further disclosures other than treatment, payment or health care operation, without the specific written authorization of the person to whom it pertains, or as otherwise permitted by such regulations.**

Bureau of Genetic Services • 570 East Woodrow Wilson • Post Office Box 1700 • Jackson, MS 39215-1700
601-576-7619 • 1-866-HLTHY4U • www.HealthyMS.com

*Equal Opportunity in Employment/Services*