State of California – Health and Human Services Agency

California Department of Public Health

Genetic Disease Screening Program

Submit Online

Request for Newborn Screening Hemoglobin Results

REQUESTOR'S INFORMATION	
First Name	Last Name
Date of Birth (mm/dd/yyyy)	GENDER MALE ☐ FEMALE ☐
Were You Part of a Multiple Birth? (in other words, were you a twin, triplet or more?) NO ☐ YES ☐	If yes, where were you in the birth order? (usually A, B, C or 1, 2, 3…etc)
Hospital of Birth	City Where Birth Hospital is Located
REQUESTOR'S BIRTH MOTHER'S INFORMATION	
First Name	Last Name
Date of Birth (mm/dd/yyyy)	Maiden Name
Other Names Used	**CHILD'S NBS FORM #** (for parent requests only)
SIGNATURE	
You do not need an inked signature if you choose to submit your request electronically. Your printed name, email address and today's date constitute your digital signature. The undersigned hereby authorizes the release of the Newborn Screening Hemoglobin test results from the records of the California Genetic Disease Screening Program to the email address(es) provided below. If the undersigned is a parent of a newborn who screened positive for a hemoglobin disorder, this request also authorizes release of the results to the child's hematologist for the purposes of diagnosis, treatment, and counseling. Authorization for release expires one year from date signed. Parent or legal guardian should sign if requester is under the age of 18 years.	
Your Printed Name or Signature	Date (mm/dd/yyyy)
Best email address for us to send you your results	Best phone number to reach you at

CDPH Genetic Disease Screening Program (GDSP) – Newborn Screening Program
850 Marina Bay Parkway, Room F-175, Richmond, CA 94804
Information can be found at: CDPH Newborn Screening Program
E-mail questions to: NBSHbResults@cdph.ca.gov

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Please Note:

- **Results are only available for California births after 2/26/1990**

You must have Adobe's Acrobat Reader to use this form.

If unable to fill form out and submit electronically, please: Print form, fill out with clear **BLOCK PRINT**, sign and return by mail or by email (JPG/PDF) to NBSHbResults@cdph.ca.gov

Print

You have the right to retain a copy of this consent. You have the right to revoke this consent at any time by writing to:

Chief, Genetic Disease Screening Program
850 Marina Bay Parkway, F175, Richmond, CA 94804

The Genetic Disease Screening Program is not responsible for further disclosures of the information by other parties that may result from complying with this consent.

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.

Privacy Notification

The Genetic Disease Screening Program (GDSP) is defined as a health care provider under HIPAA and is a covered entity. GDSP is therefore required to distribute a Notice of Privacy Practice (NPP). The collection and exchange of personal health information between covered providers for the purpose of treatment, payment, or health care operations with GDSP and our agents in connection with the newborn and prenatal screening programs is permitted by HIPAA and required by state law without special authorization or Business Associates Agreements.