



Department of Health and Human Services
Maine Center for Disease Control and Prevention
Children with Special Health Needs
Maine Newborn Bloodspot Screening Program
286 Water Street, Augusta, Maine 04333-0011
Tel.: (207) 287-8188; Fax: (207) 287-4743
TTY Users: Dial 711 (Maine Relay)

Authorization for Release of Information
Permission to Provide Newborn Bloodspot Screening Report
Sickle Cell Screening Results for College Athletes

I request that the Maine Newborn Bloodspot Screening Program (MNBSB) provide a copy of the Newborn Bloodspot Screening Report on the person below for the purpose of determining Sickle Cell Screening Results for participation in athletics:

Student Name: _____ DOB: _____

Mother's Full Name (at time of student's birth): _____

Mother's Date of Birth: _____ Student Hospital of Birth: _____

SECTION I

I, _____, give my permission to the Maine Newborn Bloodspot Screening Program, Department of Health and Human Services, Maine Center for Disease Control and Prevention, 286 Water St., Augusta, ME 04333-0011 PHONE 207-287-5357 FAX 207-287-4743 to share MY NEWBORN BLOODSPOT SCREENING RESULTS with the medical provider listed in below:

Provider Name _____

Provider Practice Name _____

Provider Address _____

PHONE: _____ FAX: _____

SECTION II

Student Signature _____ Date _____

Print Student Name _____

If this form is being filled out by someone who has the legal authority to act for the student (such as the parent of a minor child, a court appointed guardian or executor, or health care agent), please:

Print Name of person filling out this form: _____

Signature of the person filling out this form: _____

Relationship to Student _____

FAX OR MAIL FORM ATTENTION: MAINE NEWBORN BLOODSPOT SCREENING PROGRAM – SICKLE CELL PARTICIPATION IN ATHLETICS

To be completed by ME Newborn Bloodspot Screening Program (MNBSB)	
Date Request Received:	Signature of Staff:
Accession #:	Date of Specimen Collection: