Reset Form

REQUEST FOR DESTRUCTION OF DRIED BLOOD SPOT

State Form 55650 (8-14) / Form D

Indiana State Department of Health

You may request that your/your baby's dried blood spot sample be destroyed by completing and sending this form to the Newborn Screening Program. However, please keep in mind that no samples will be destroyed until the child has reached six (6) months of age in case additional testing related to newborn screening needs to be performed.

In order for the Indiana State Department of Health (ISDH) Newborn Screening Program to locate your/your son's/daughter's dried blood spot sample, certain pieces of information are needed.

Please fill out each of the lines below ***with the correct information for the person/child whose dried blood spot is being requested to be destroyed.***

- If you are requesting the destruction of your own dried blood spot sample, please fill in your own information. ***Anyone who is at least eighteen (18) years old may request his/her own dried blood spot sample to be destroyed.***
- If you are requesting the destruction of your son's/daughter's dried blood spot sample, then please insert your son's/daughter's information.

Name at *birth*: _____ Date of birth *(month, day, year)*:_____

Location of birth *(name of Indiana hospital/midwifery where you or your child was born)*:

_____

***Birth mother's* first name: _____ *Birth mother's* last name: _____**

***Birth mother's maiden name*: _____**

Requestor Full Name: _____Requestor Telephone Number: (_____)_____

Requestor Relationship to child:_____

Requestor Address: _____, _____, _____
Street City State

I, _____, request that my/my child's (the child I have listed on this form) dried blood spot
Print name here
sample be destroyed and give permission to the Indiana State Department of Health and the Indiana University Newborn Screening Lab to complete this destruction.

_____ _____
Individual or Parent/Legal Guardian Signature Date *(month, day, year)*

Purpose: Identification is required from an individual when submitting a Health Insurance Portability and Accountability (HIPAA) request regarding Protected Health Information (PHI). Below are the lists of acceptable identification that can be provided by the individual. Please provide a photocopy of one item from List A **OR** two items from List B with your request.

List A	List B
Provide photocopy of one (1) of the following items:	If you cannot provide any items from List A, provide a photocopy of two (2) of the following items:
Valid Driver License	Social Security Card
Valid State Identification	Stamped Social Security Print-out
Work Identification with Signature	Credit Card or Bank Card with Signature (backside only)
Military Identification with Signature	Motor Vehicle Registration (must be six (6) months old) – NO VEHICLE TITLES
School Identification with Signature	Valid Indiana Gun Permit
Veterans Identification Card	Rental Agreement/Lease (must be six (6) months old)
Probation Identification Card	Valid Professional License
Passport	State Agency Referral
	Employment Application (must be six (6) months old) – NO CHECK STUBS
	Employment Verification on Letterhead
	Library Card with Signature
	Previous Year Signed Tax Return – NO W2 STATEMENTS

A letter of confirmation will be sent to the address listed on this request once the destruction of your or your child's dried blood spot has been completed. If we have any questions regarding your request, we will contact you using the information you provided on this request. Please make sure all fields are completed in full.

If you have any questions about this form, please call the ISDH Genomics and Newborn Screening Program at (888) 815-0006. Please fax this request to (**317) 234-2995** or mail to:

Genomics and Newborn Screening Program
Indiana State Department of Health
2 North Meridian St., 2E
Indianapolis, In 46204