



**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 sample be destroyed and give permission to the Indiana State Department of Health and the Indiana University Newborn Screening Lab to complete this destruction.
Print name here

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**