Puerto Rico Center for Hereditary Diseases
PR Newborn Screening Program
University of Puerto Rico • Medical Sciences Campus
School of Medicine

REQUEST FOR NEWBORN SCREENING RESULTS

This authorization complies with the requirements of the HIPAA Privacy Standards. **Parent and legally authorized representative (LAR) (if results are not requested by parents) must present current valid government-issued photo identification.**

Please provide all the information below.

I am requesting the Newborn Screening results of:

Mother's name:			Child's Information: ☐ F ☐ M ☐ Single ☐ Twin 1 2
Child's Hospital of Birth:			
Child's Date of Birth:		NBS ID Number (if available):	

Parent or legally authorized representative information:

Name of person authorized to receive child's NBS results:		Relationship with child:
Address:	Phone Number:	

I hereby certify that all information provided in this form is true and correct.

Print/Type Name of Parent _____

Print/Type Name of LAR _____

Signature of Parent / Date _____

Signature of LAR / Date _____