THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health and Social Services

DIVISION OF PUBLIC HEALTH
Section of Women's, Children's and Family Health

3601 C Street, Suite 322
Anchorage, Alaska 99503
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AUTHORIZATION FOR RELEASE OF DRIED BLOODSPOT

Child's Name: _____ Date of Birth: _____

Lab Number: _____

Other Names Under Which Records Might Be Filed: _____

Organization Releasing Dried Bloodspot: Alaska Newborn Bloodspot Screening Program

Person/Organization Request and Receiving Dried Bloodspot:

_____

Address for receipt of bloodspot: _____

The purpose of the release of this dried bloodspot is: _____

Note: The Alaska Newborn Bloodspot Screening Program does NOT permit release of dried bloodspots for the following:

- Routine paternity testing
- Analysis of medical conditions tested previously by the Iowa State Hygienic Laboratory in the Newborn Bloodspot Screening process
- Research, unless specifically requested by the parent

I hereby authorize the use or disclosure of my child's dried bloodspot as described above under purpose of the release. I understand that this authorization is voluntary. I may revoke this authorization at any time by notifying the organization releasing the dried bloodspots in writing, but if I do, it won't have any effect on actions taken on this authorization before my revoke was received. I understand that I may request a copy of this signed authorization.

This authorization expires on the following date or event: _____

_____ _____

Signature of Parent or Personal Representative (Or Witness if signature is by mark) — Date

_____ _____

Printed Name of Personal Representative or Witness — Description of Personal Representative's Authority

NOTE: This authorization was revoked on: _____ *(see attached revocation)*
Date

Revised: 3/11/2020

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REVOCATION SECTION *

I do hereby request that this authorization to release the bloodspot of: _____
(Printed Name of Client)

Described on the reverse side of this form, be rescinded, effective: _____
(Date)

I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____
Signature of Client or Personal Representative Date

_____ _____
Printed Name of Personal Representative or Witness Description of Personal Representative's Authority

INSTRUCTIONS:

The elements of this form described below (x – xx) and marked with an asterisk (*) MUST BE COMPLETED. There are NO exceptions. Incomplete authorization forms are invalid and WILL NOT BE PROCESSED.

1. **Client Information** *: Enter the Name, Lab Number, and Date of Birth (if known) of the individual whose dried bloodspot is being released or requested. At least one identifier other than name must be present – e.g. Lab Number or DOB.

2. **Organization Releasing and Receiving Dried Bloodspot** *: The 'Alaska Newborn Bloodspot Screening Program' is the organization releasing the dried bloodspot, and is prefilled on the form. The client or client's representative should indicate a specific name (and address, if known) of the individual(s) or organization(s) receiving the dried bloodspot.

3. **Purpose of the Release of Dried Bloodspot** *: A specific description of the purpose of the release should be indicated, in order to ensure the release is NOT for the purpose of:
    - Routine paternity testing
    - Analysis of medical conditions tested previously by the Iowa State Hygienic Laboratory in the Newborn Bloodspot Screening process
    - Research, unless specifically requested by the parent

4. **Expiration Date/Event*:** Enter a date or event that is reasonable and acceptable to the parent or client representative. For instance, "*One year from the date of this authorization"* is generally accepted as a reasonable expiration date.

5. **Signature and Dates*:** The parent or client representative who is requesting the child's dried bloodspot should sign and date the form. If an authorized representative is signing on behalf of the parent or client representative, the representative's "legal authority" to act on their behalf must be verified first and then described in the appropriate space. Legal authority includes but is not limited to an individual who has power of attorney over the affairs of the client, parent, or client representative of the child whose dried bloodspot is being released or requested.

6. **Revocation Date:** The revocation date on the reverse side of the consent form does NOT need to be completed UNLESS the individual has revoked this authorization. Complete all information requested in the "Revocation Section."

7. **ALL authorization forms MUST be retained for SIX (6) YEARS from the date of signature**. This form should be stored in the client file, if one is maintained. Some programs have procedures requiring the form, or a copy of the form be retained solely or additionally by the Division Privacy Official. Please refer to the appropriate Division or Program specific procedures or inquire with your Division Privacy Official regarding any additional retention requirements of authorization forms.
8. If requested, provide a copy of this authorization to the parent or client's representative.

QUESTIONS?

Contact the DHSS Privacy Official at (907) 465-2150 with any concerns you may have.

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL