Reset Form

PUBLIC HEALTH GENETICS NEWBORN SCREENING ACCESS REQUEST

State Form 55649 (R4 / 1-26)
INDIANA DEPARTMENT OF HEALTH
PUBLIC HEALTH GENETICS PROGRAM

Indiana Department of Health
NEWBORN SCREENING INDIANA

CONFIDENTIAL INFORMATION
per 45 CFR § 164.524

The purpose of this form is for a patient, legal guardian, or physician to request to inspect and/or obtain copies of protected health information or medical records (and designated record sets defined by 45 CFR § 164.501) maintained by us or our business associates, except that you are not entitled to inspect or obtain a copy of psychotherapy notes, information compiled in anticipation of or for use in any civil, criminal, or administrative proceeding, and certain information and records excluded from disclosure under 42 U.S.C. § 263a and other law.

To exercise your right of access, please complete and sign this form and submit it with a photocopy of your proof of identification as described below.

By E-mail to: NewbornScreening@health.in.gov

By mail to: Attn: Privacy Officer, Office of Legal Affairs
Indiana Department of Health
2 North Meridian Street Indianapolis, IN 46204

We require certain pieces of information so that we, the Indiana Department of Health *Public Health Genetics Program*, can process your request. If you have any questions, please call us at (888) 815-0006.

SECTION A: Information Requested

Please *indicate* which information you are requesting for the person described below:

- ☐ **Newborn Screening Results for a child born in 2007 or before**
- ☐ **Newborn Screening Results for a child born in 2008 or after**
- ☐ **Dried Blood Spot Specimen Punch**

Results will be provided for Newborn Screenings ("*NBS Results*") for all conditions that were on Indiana's panel at the time of each newborn screening. *Dried Blood Spot Specimen Punches* are for further genetic testing within six (6) months and up to three (3) years after the birth. *Dried Blood Spot Punches* can only be provided if the patient's parent or guardian consented to storage of the residual dried blood spots at birth.

- If you are requesting a copy of your NBS Results, please fill in your own information. Anyone who is at least eighteen (18) years old must complete their own request.
- If you are submitting this request on behalf of your child, please provide their information.

Please provide a brief description of the reason you want this information released:

_____

_____

Please describe the information you want released from your health record:

_____

_____

SECTION B: Patient Information

Patient's Name at Birth: _____ Date of Birth *(month, day, year)*: _____

Address: _____

Telephone: _____

Birth Mother's First and Last Names: _____

Location of Birth *(name of Indiana Hospital / midwifery where patient was born)*: _____

SECTION C: Information of Person to Whom Records Are to Be Released

Name of Person or Provider: _____

Address: _____

Telephone: _____ Fax: _____

E-mail: _____

By providing your email address you consent to receive communications about this form and this request by email.

Preferred delivery method for records: ☐ Encrypted E-mail ☐ Postal Mail ☐ Fax

SECTION D: AUTHORIZATION FOR ACCESS

I understand that once the requested information has been disclosed, it may no longer be protected by the HIPAA Privacy Rule. I understand that any covered entity seeking this authorization may not require my signature on this form to provide or process treatment, payment, enrollment, or eligibility for benefits. I may revoke my authorization at any time, in writing, except to the extent that any action already was taken in reliance on my authorization. Written revocation will be effective upon receipt by the Privacy Officer. If I do not revoke this authorization in writing, this request for access will automatically expire:

☐ thirty (30) days from the date it was signed; or

☐ upon receipt of the requested records by the person named in Section C above; or

☐ after an event / condition occurs described as: _____

_____

_____

If nothing is selected, then the request will expire sixty (60) days after the date it was made according to Ind. Code § 16-39-1-1.

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE

If the Patient is over age eighteen (18), then the Patient shall sign and date below and provide the Patient's identification as required below. If the Patient is under age eighteen (18), then the Patient's parent, guardian, or representative shall sign and date below on the Patient's behalf and provide the parent, guardian, or representative's own identification as required below.

Signature:_____ Date *(month, day, year)*: _____

Full Name *(print)*:_____

Full Name of Parent / Guardian *(print)*: _____

Relationship to Patient: _____ Date of Birth *(month, day, year)*: _____

Address: _____

Telephone: _____ E-mail:_____

By providing your e-mail address you consent to receive communications about this form and this request by e-mail.

Identification is required for all requests for protected health information that are submitted under HIPAA. Below are lists of acceptable identification. **Please provide a legible photocopy of one item from List A OR two items from List B with your request.**

List A **(Preferred)** *Provide a photocopy of one (1) of the following items:*

- **Valid Driver License *(both sides)***
- **Valid State ID *(both sides)***
- Work ID with Signature
- Military ID with Signature
- School ID with Signature
- Veterans ID Card
- Probation ID Card
- Passport

List B *If you cannot provide any items from List A, provide a photocopy of two (2) of the following items:*

- Social Security Card
- Stamped Social Security Printout
- Credit Card or Bank Card with Signature *(back side only)*
- Motor Vehicle Registration *(must be six (6) months old)* – NO VEHICLE TITLES
- Valid Indiana Gun Permit
- Rental Agreement/Lease *(must be six (6) months old)*
- Valid Professional License
- 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 W2STATEMENTS

We must respond to an access request within thirty (30) days of its receipt, unless the requested records are off-site, in which case we have sixty (60) days to respond.