Request for Newborn Screening Results
& Physician Attestation Statement

Child's Name: _____

Child's Date of Birth: _____

Child's Hospital of Birth: _____

Child's Sex: ☐ Male ☐ Female ☐ Unspecified

Medical Record Number from the Hospital of Birth: _____

AKA (Aliases): _____

Mother's Name: _____

I, the undersigned **physician** of the above identified individual, certify that the following are true:

A. I am requesting the Newborn Screening results as the physician of record who is providing medical care for this individual.

B. I understand that per Part 58-1 of the New York Codes, Rules and Regulations (NYCRR) Title 10, Clinical Laboratories, Section 58-1.8 results are to be used in the conduct of my medical practice or in the fulfillment of my official duties.

Signed: _____

Dated: _____

Printed Name: _____

Medical License Number: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

Completed forms should be returned to the Newborn Screening Program via fax to 518-474-0405 or secure email to nbsinfo@health.ny.gov.