Form to Request Destruction of Residual Newborn Screening Specimen

Child's Name: ______________________________

Child's Date of Birth: ______________________________

Parent or Guardian(s) Name: ______________________________

Name of Child's Primary Health Care Provider: ______________________________

☐ Photocopy of Government issued photo identification or notarized verification of identity is attached.

Parent or Guardian Signature ______________________________

Date ______________________________

You may return this signed form to the Iowa Newborn Screening Program at:

Email: Kimberly.Piper@idph.iowa.gov
Fax: 515-725-1760
Postal Service: Iowa Department of Public Health
Center for Congenital and Inherited Disorders
321 E. 12th Street
Des Moines, IA 50319-0075

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