

# HEALTH INFORMATION EXCHANGE OF ELECTRONIC NEWBORN SCREENING RESULTS

## CONSENT FORM FOR AGENCIES USING HIE FOR NBS TEST RESULTS

**INSTRUCTIONS:** This form is for agencies to establish and maintain a relationship with the State of California, Department of Public Health, Genetic Disease Screening Program (GDSP) for the purpose of health information exchange (HIE). It is to be used to keep GDSP informed of data transmission preferences and communication contacts. Health Practice Management firms and Physician/Medical groups must also list clinicians who have given your agency consent to collect their HIE for transmission back to the individual physician or midwife.

AGENCY TYPE			
CHOOSE YOUR AGENCY TYPE:	<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> HEALTH PRACTICE MANAGEMENT FIRM	<input type="checkbox"/> MEDICAL or PHYSICIANS GROUP
			NPI #: <i>(not applicable for Health Practice Management firms)</i>
AGENCY NAME		STREET ADDRESS	
CITY		STATE	ZIP

DATA TRANSMISSION PREFERENCE			
HOW WOULD YOU LIKE TO RECEIVE THE NEWBORN SCREENING RESULTS?	<input type="checkbox"/> PDF MAILER ONLY	<input type="checkbox"/> ELECTRONIC HL7 MAILER	<input type="checkbox"/> BOTH PDF AND ELECTRONIC HL7 MAILER
			EFFECTIVE DATE:

PRIMARY CONTACT FOR HIE COMMUNICATION			
FIRST NAME	LAST NAME	TITLE	REPLACES CURRENT PRIMARY CONTACT <input type="checkbox"/>
STREET ADDRESS	CITY	STATE	
TELEPHONE NUMBER <i>(With area code)</i>	EXTENSION	EMAIL ADDRESS	EFFECTIVE DATE:

PLEASE PROVIDE AT LEAST ONE ADDITIONAL HIE CONTACT					
<b>CONTACT 1</b>	FIRST NAME	LAST NAME	TITLE	<input type="checkbox"/> ADD	
	STREET ADDRESS	CITY	STATE	ZIP	<input type="checkbox"/> REMOVE
	TELEPHONE NUMBER <i>(With area code)</i>	EXTENSION	EMAIL ADDRESS	EFFECTIVE DATE:	
<b>CONTACT 2</b>	FIRST NAME	LAST NAME	TITLE	<input type="checkbox"/> ADD	
	STREET ADDRESS	CITY	STATE	ZIP	<input type="checkbox"/> REMOVE
	TELEPHONE NUMBER <i>(With area code)</i>	EXTENSION	EMAIL ADDRESS	EFFECTIVE DATE:	
<b>CONTACT 3</b>	FIRST NAME	LAST NAME	TITLE	<input type="checkbox"/> ADD	
	STREET ADDRESS	CITY	STATE	ZIP	<input type="checkbox"/> REMOVE
	TELEPHONE NUMBER <i>(With area code)</i>	EXTENSION	EMAIL ADDRESS	EFFECTIVE DATE:	

AUTHORIZATION AND APPROVAL
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THE UNDERSIGNED HEREBY AUTHORIZE AND APPROVE ACCEPTANCE OF NEWBORN SCREENING RESULTS FOR THE ATTACHED LIST OF PHYSICIANS/MIDWIVES.

NAME PRINTED	SIGNATURE	DATE SIGNED (MM/DD/YYYY)
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**CLINICIANS WHO HAVE GIVEN CONSENT FOR YOUR AGENCY TO RECEIVE THEIR HIE**

**CLINICIAN 1**

FIRST NAME			LAST NAME		CLINICIAN TYPE: PHYSICIAN <input type="checkbox"/> MIDWIFE <input type="checkbox"/>
FACILITY NAME			TELEPHONE NUMBER <i>(With area code)</i>	EXTENSION	STATUS CHANGE: ADD <input type="checkbox"/> REMOVE <input type="checkbox"/>
STREET ADDRESS			EMAIL ADDRESS		EFFECTIVE DATE:
CITY	STATE	ZIP	LICENSE #	NPI #	

**CLINICIAN 2**

FIRST NAME			LAST NAME		CLINICIAN TYPE: PHYSICIAN <input type="checkbox"/> MIDWIFE <input type="checkbox"/>
FACILITY NAME			TELEPHONE NUMBER <i>(With area code)</i>	EXTENSION	STATUS CHANGE: ADD <input type="checkbox"/> REMOVE <input type="checkbox"/>
STREET ADDRESS			EMAIL ADDRESS		EFFECTIVE DATE:
CITY	STATE	ZIP	LICENSE #	NPI #	

**CLINICIAN 3**

FIRST NAME			LAST NAME		CLINICIAN TYPE: PHYSICIAN <input type="checkbox"/> MIDWIFE <input type="checkbox"/>
FACILITY NAME			TELEPHONE NUMBER <i>(With area code)</i>	EXTENSION	STATUS CHANGE: ADD <input type="checkbox"/> REMOVE <input type="checkbox"/>
STREET ADDRESS			EMAIL ADDRESS		EFFECTIVE DATE:
CITY	STATE	ZIP	LICENSE #	NPI #	

**CLINICIAN 4**

FIRST NAME			LAST NAME		CLINICIAN TYPE: PHYSICIAN <input type="checkbox"/> MIDWIFE <input type="checkbox"/>
FACILITY NAME			TELEPHONE NUMBER <i>(With area code)</i>	EXTENSION	STATUS CHANGE: ADD <input type="checkbox"/> REMOVE <input type="checkbox"/>
STREET ADDRESS			EMAIL ADDRESS		EFFECTIVE DATE:
CITY	STATE	ZIP	LICENSE #	NPI #	

**CLINICIAN 5**

FIRST NAME			LAST NAME		CLINICIAN TYPE: PHYSICIAN <input type="checkbox"/> MIDWIFE <input type="checkbox"/>
FACILITY NAME			TELEPHONE NUMBER <i>(With area code)</i>	EXTENSION	STATUS CHANGE: ADD <input type="checkbox"/> REMOVE <input type="checkbox"/>
STREET ADDRESS			EMAIL ADDRESS		EFFECTIVE DATE:
CITY	STATE	ZIP	LICENSE #	NPI #	

GENETIC DISEASE SCREENING PROGRAM • NEWBORN SCREENING BRANCH • 850 MARINA BAY PARKWAY, F175 • RICHMOND, CA 94804

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