



**PARENT REQUEST TO HAVE  
NEWBORN BLOOD SPECIMEN CARD DESTROYED**

*If mother is unable to sign, please enclose child's state-issued birth certificate with official seal.  
(It will be returned to parent after it has been reviewed.)*

**Parent or Parents Making the Request:**

Mother's Name (Last, First): \_\_\_\_\_

Mother's Maiden Name: \_\_\_\_\_

Mother's e-mail address: \_\_\_\_\_

Father's Name (Last, First): \_\_\_\_\_

Father's e-mail address: \_\_\_\_\_

**Child's Information:**

Newborn's Name (Last, First): \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Hospital of Birth: \_\_\_\_\_

Address of child at time of birth: \_\_\_\_\_

**Current Mailing Address:**

(if different from above)

\_\_\_\_\_  
\_\_\_\_\_

Phone: (    ) \_\_\_\_\_ - \_\_\_\_\_

**I understand that any person who requests or obtains any record containing personal information from the California Department of Public Health under false pretenses will be guilty of a misdemeanor and fined up to \$5,000 or imprisoned up to one year or both.**

Mother's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Father's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**(Parent or Legal Guardian should sign only if request is for a minor under 18 years of age)**

**Mail completed form to:**

California Biobank Program Coordinator  
CDPH – GDSP  
850 Marina Bay Pkwy., F175, MS 8200  
Richmond, CA 94804  
e-mail: [CaliforniaBiobank@cdph.ca.gov](mailto:CaliforniaBiobank@cdph.ca.gov)