

If you choose to participate in telephone counseling and family testing, please have this with you when you call the toll free number.

Statement of Informed Consent for Hemoglobin Blood Test

I hereby authorize the laboratory to draw a sample of my/ my child's blood for hemoglobin testing as part of the California Newborn Screening Program.

1. I understand general information on Sickle Cell Disease and Sickle Cell Trait and the difference between them.
2. I understand that blood collection procedures involve venipuncture and the risk involved.
3. I understand that my participation in the procedure is entirely voluntary.
4. I recognize my right for refusal of service or to withdraw from the program at anytime.
5. I recognize my right to a copy of my test results and consent form if I so desire.
6. I understand that family blood tests may reveal that a parent and child are not biologically related.
7. I understand that all information obtained is confidential. I authorize release of hemoglobin testing results to California Department of Public Health Genetic Disease Screening Program for purposes of obtaining telephone counseling and family testing. Test results will be sent to my child's doctor. Other requests for results will be released only with my signed consent. Information may be used for research without identifying me in any way.
8. I understand that this authorization does not expire unless rescinded in writing by the undersigned.
9. I understand I have the right to retain a copy of this authorization. I understand that I have the right to revoke this authorization at any time by writing to Chief, Genetic Disease Screening Program at 850 Marina Bay Parkway, Richmond, CA 94804 as stated in the privacy notice.

My signature below indicates that:

I have read or have had read to me, the above information and I understand it. I have had an opportunity to discuss it and my questions have been answered.

Signed _____ Date _____

Name (Print)

Last Name (Print)

Telephone Number