NCAA STUDENT ATHLETE REQUEST FOR NEWBORN SCREENING HEMOGLOBIN RESULTS

PLEASE NOTE

****** It can take up to 30 days to process your request. If you need your results in less time, we recommend having a sickle cell test run by your physician.**

****** Results are only available for California births after 2/26/1990.**

- **You must have Adobe's Acrobat Reader (http://get.adobe.com/reader/) to use this form.**
- **Enter data on form, print it, sign it and mail or fax it. You can also scan or take a picture and email it (see contact information below).**
- **Parents cannot request results for offspring 18 years or older.**
- **For more information go to www.cdph.ca.gov/programs/nbs and select NCAA Athletes.**
- **Required questions are underlined - enter N/A if you do not have the answer.**

Enter data then...

Step 1: Submit Electronically and then...

Step 2: Print and Sign form and then...

Step 3: Fax, mail or email (JPG/PDF)

If unable to fill form out and submit electronically please: Print form, fill out with clear BLOCK PRINT, sign and return by FAX, mail or email (JPG/PDF).

STUDENT'S INFORMATION

FIRST NAME	LAST NAME	DATE OF BIRTH (MM/DD/YYYY) *(Results only on birthdates after 02/26/1990)*
WEARE YOU PART OF A MULTIPLE BIRTH? *(in other words were you a twin, triplet or more?)* ☐ NO ☐ YES	IF YES, WHERE WERE YOU IN THE BIRTH ORDER? *(Usually A, B, C or 1, 2, 3... etc.)*	GENDER ☐ MALE ☐ FEMALE
BIRTH HOSPITAL	CITY WHERE BIRTH HOSPITAL LOCATED	

BIRTH MOTHER'S INFORMATION

FIRST NAME	LAST NAME	DATE OF BIRTH
MAIDEN NAME	OTHER NAMES USED	CITY MOTHER LIVED IN AT TIME OF STUDENT'S BIRTH

RELEASE RESULTS TO

PROVIDE AN EMAIL ADDRESS WHERE ADDITIONAL ENCRYPTED RESULTS ARE TO BE SENT

If providing more than one address, separate addresses using a semi colon (;)

AUTHORIZATION FOR THE RELEASE OF RECORDS WILL EXPIRE ON:

(A default 1 year from today is given. if a different date is desired, please feel free to change.)

SIGNATURE

THE UNDERSIGNED HEREBY AUTHORIZES THE RELEASE OF NEWBORN SCREENING HEMOGLOBIN TEST RESULTS FROM THE RECORDS OF THE CALIFORNIA GENETIC DISEASE SCREENING PROGRAM. MUST BE SIGNED BY STUDENT IF 18 OR OLDER. PARENT OR LEGAL GUARDIAN SHOULD SIGN ONLY IF STUDENT UNDER THE AGE OF 18.

SIGNATURE (STUDENT IF OVER 18, PARENT/GUARDIAN IF STUDENT NOT OVER 18)	PRINTED NAME	DATE SIGNED (MM/DD/YYYY)
BEST EMAIL ADDRESS FOR US TO SEND YOU YOUR RESULTS	BEST PHONE NUMBER TO REACH YOU *(Just type in numbers, parentheses and slashes will fill in)*	

YOU HAVE THE RIGHT TO RETAIN A COPY OF THIS CONSENT. YOU HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME BY WRITING TO: CHIEF, GENETIC DISEASE SCREENING PROGRAM AT 850 MARINA BAY PARKWAY, F175, RICHMOND, CA 94804. THE GENETIC DISEASE SCREENING PROGRAM IS NOT RESPONSIBLE FOR FURTHER DISCLOSURES OF THE INFORMATION BY OTHER PARTIES THAT MAY RESULT FROM COMPLYING WITH THIS CONSENT.

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.

PRIVACY NOTIFICATION

The Genetic Disease Screening Program (GDSP) is defined as a health care provider under HIPAA and is a covered entity. GDSP is therefore required to distribute a Notice of Privacy Practice (NPP).

The collection and exchange of personal health information between covered providers for the purpose of treatment, payment, or health care operations with GDSP and our agents in connection with the newborn and prenatal screening programs is permitted by HIPAA and required by state law without special authorization or Business Associates Agreements.

GENETIC DISEASE SCREENING PROGRAM (GDSP) ● NEWBORN SCREENING BRANCH
850 MARINA BAY PARKWAY, F175 ● RICHMOND, CA 94804 ● Website: www.cdph.ca.gov/programs/nbs
E-mail questions to: NCAANBSResults@cdph.ca.gov ● FAX: 510/412-1559