



REQUEST FOR DESTRUCTION OF DRIED BLOOD SPOT

State Form 55650 (R2 / 8-26) / Form D
INDIANA DEPARTMENT OF HEALTH
GENOMICS AND NEWBORN SCREENING PROGRAM

You may request that your child's dried blood spot sample be **destroyed** by completing and sending this form to the Genomics and Newborn Screening (GNBS) Program.

Please review the criteria below to ensure your request is valid:

- All samples are kept until the child has reached six (6) months after the sample was collected in case additional testing related to newborn screening needs to be performed. No samples will be destroyed before six (6) months after the time of sample collection.
- If you previously consented to storage of your child's dried blood spot sample, the sample will be destroyed three (3) years after the sample was collected. You may request that the sample be destroyed before three (3) years after time of collection by completing and sending this form.

In order for the Indiana Department of Health GNBS Program to locate your child's dried blood spot sample, certain pieces of information are needed.

Please fill out each of the fields below with the correct information for the child whose dried blood spot sample you are requesting to be **destroyed**.

First and last name of child at birth	Date of birth of child (<i>month, day, year</i>)
Location of birth (<i>name of the Indiana hospital/midwifery where child was born</i>)	
First and last name of birth mother	Maiden name of birth mother
First and last name of requestor	Requestor's relationship to child
Address of requestor (<i>number and street, city, state, and ZIP code</i>)	
Telephone number of requestor (<i>include area code</i>)	E-mail address of requestor

I hereby request that the dried blood spot sample of the above named child be **destroyed** and I give permission to the Indiana Department of Health and the state-acquired newborn screening laboratory to complete this request for **destruction**.

Signature of requestor	Date of request (<i>month, day, year</i>)
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