IOWA | Health and Human Services
Public Health

FORM TO REQUEST DESTRUCTION OF RESIDUAL NEWBORN SCREENING SPECIMEN

Upon receipt of this form directing the Iowa Newborn Screening Program to destroy your child's residual newborn screening dried blood spot specimen, we will proceed with the destruction by incineration of the specimen immediately.

Child's Name at Birth: _____

Child's Date of Birth: _____

Parent or Guardian Name: _____

Name of Child's Primary Health Care Provider:

_____

Please check:

☐ Photocopy of government issued photo identification or notarized verification of identity is attached.

Parent or Guardian Signature: _____

Date: _____

Please return this signed form to the Iowa Newborn Screening Program at:

Email: Kimberly.NoblePiper@hhs.iowa.gov

Fax: 515-242-6013

Postal Service: Iowa Department of Health and Human Services
Center for Congenital and Inherited Disorders
321 E. 12th Street
Des Moines, IA 50319-0075

If you need help completing this form or want to request an accommodation, contact access@hhs.iowa.gov. Business hours are Monday-Friday, 8:00 am – 4:30 pm.

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