Commonwealth of Virginia
Department of General Services
Division of Consolidated Laboratory Services
Richmond, Virginia

Authorization and Consent Release-Hemoglobinopathy

SECTION 1: Patient Information at the time of testing
(*Please print***):**

_____ _____ _____
First Name Last Name Middle Initial

Male Female _____ _____
Sex (Circle one) Date of Birth Phone number (XXX-XXX-XXXX)

_____ _____ _____ _____
Current Address Street, Apt. # City State Zip Code

_____ _____
Hospital of Birth Physician of Record at the Time of Collection/Concern

_____ _____ _____
Mother's Last Name at Birth First Name Middle Name or Initial

_____ _____ _____ _____ _____
Mother's Address at Birth Street Apt. # City State Zip Code

SECTION 2: Authorization of Release:
I hereby authorize the Department of General Services, Division of Consolidated Laboratory Services, Richmond Virginia, 23219, to release, disclose and deliver the result(s) indicated above. **Please be aware this request may take up to thirty days to process and deliver**.

Send report to:
_____
_____
_____

Disclaimer:
Using the standard initial screening methodology of isoelectric focusing (IEF), this laboratory can presumptively identify the following major hemoglobin (Hb) bands: F, A, S, D, C, E, and hemoglobin Bart's. Subsequent HPLC methodology permits quantification of the abnormal Hb variants. The normal hemoglobin pattern in a newborn is FA. Hemoglobin bands other than the ones listed above will be reported as FAV with "V" designating an unidentified band. While the sensitivity of IEF and HPLC are excellent, result and their interpretation can be compromised by extreme prematurity or previous blood transfusions. If further information is required regarding these results, please contact your physician.

Re-disclosure:
This release does not authorize re-disclosure of medical information beyond the limits of this consent. The recipient of this information is prohibited from using the information for other than the stated purpose, and from disclosing it to any other party without further authorization. I therefore understand this is a one-time authorization.

SECTION 3: **Validity: I authorize the release of information as indicated above**

Date **Patient Name** (*Print)* **Signature**

Date **Parent/Guardian /Power of Attorney** (Print) **Parent/Guardian/Power of Attorney** (Signature)

Note (Power of Attorney): If signing as the Power of Attorney, please provide a copy of the signed legal documentation providing authority as the Power of Attorney for the patient noted on this authorization and consent release form.

SECTION 4:
Given under my hand and seal of office this _____month, day of_____, _____ (year)

Notary Public's Signature

(Personalized Seal):

If a notary is unavailable, you may send a photocopy of your driver's license as proof of your identity.

This area is for Data Entry/IT Support Group's use only:

Date Received Initials Date Processed Initials

Comments: