



State of California—Health and Human Services Agency
California Department of Public Health



**REQUEST TO HAVE
NEWBORN BLOOD SPECIMEN CARD DESTROYED**

Check here if you request the specimen **not** be
destroyed, but marked as do not use for research only:

Parent Information:

Birth Parent's Name (Last, First): _____

Birth Parent's Maiden Name: _____

Date of Birth (mm/dd/yyyy): ____ / ____ / ____

Requestor's Information:

Name (Last, First): _____

Email address: _____

Date of Birth (mm/dd/yyyy): ____ / ____ / ____ Sex: Male Female

Hospital of Birth: _____

Address at time of birth: _____

Current Mailing Address:

(if different from above)

Phone: () ____ - ____

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.

Signature: _____ Date: _____

(Parent or Legal Guardian should sign destruction request for a minor's blood specimen. If over 18, the adult child must complete and sign the form)

Mail, fax, or email completed form to: California Biobank Program Coordinator
CDPH – GDSP
850 Marina Bay Pkwy., F175, MS
8200 Richmond, CA 94804
e-mail: [California Biobank Program](#)