



# **STATE OF HAWAI'I**

**DEPARTMENT OF HEALTH**

**KA 'OIHANA OLAKINO**

**CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH**

741 SUNSET AVENUE

HONOLULU, HI 96816

**Newborn Metabolic Screening Program**

Phone (808)733-9069 | Fax (808)733-9071 | eFax (808)207-0067

## **Attestation Letter**

I, \_\_\_\_\_  
Provider attest that I am a healthcare provider for this patient. This is a request for the release of his/her newborn screening result so I may provide appropriate and continued care for my patient.

**\*COMPLETE ALL FIELDS BELOW TO RECEIVE NEWBORN SCREENING RESULTS\***

<b>Name of Patient</b> (last, first)	<b>Birth Date</b> (mm/dd/yyyy)
<b>Mother's Name</b> (last, first)	<b>Date of Appointment with Patient</b> (mm/dd/yyyy)
<b>Provider Name</b> (print)	<b>Provider Address</b>
<b>Provider Phone</b>	<b>Provider Fax</b>
<b>Provider Signature</b>	<b>Date</b>

**\*ADDITIONAL INFORMATION MAY BE REQUESTED TO CONFIRM IDENTITY OF YOUR PATIENT\***

Please fax completed document to:  
Hawai'i Newborn Metabolic Screening Program  
Fax (808)733-9071  
eFax (808)207-0067