STATE OF HAWAIʻI
DEPARTMENT OF HEALTH
KA ʻOIHANA 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, _____ attest that I am a healthcare provider for this patient. This is a request
Provider
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

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

ADDITIONAL INFORMATION MAY BE REQUESTED TO CONFIRM IDENTITY OF YOUR PATIENT

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