

OFFICE USE ONLY:

MAIL: _____
 PDF _____
 EMAIL _____
 DTB: _____

Paternity Testing Form

Date: _____/_____/_____

Contact Name _____

Number: _____ - _____ - _____

Reason for Testing (please check one):

_____ Enrollment _____ Court Ordered _____ Support Enforcement _____ Neither*

Please, to expedite the testing process, provide the following information for all of the participants of the Paternity Testing:

****Please provide identification cards for those participating.****

MOTHER			
Last Name	First Name	M.I	
Address	City	State	Zip
D.O.B. / /	Last Four Social Security # XXX-XX-	Medicaid #	

CHILD							
Last Name	First Name	M.I					
Address	City	State	Zip				
D.O.B. / /	SEX	Last Four Social Security # XXX-XX-	Medicaid #				
Ethnicity:	Caucasian	Black	American Indian	Puerto Rican	Chinese	Mexican American	Filipino
Other (Specify)	Mix (Specify race and %)						
Blood Transfusion in the past 90 days:	Yes	No	Have you ever in your life had a bone marrow transplant :	Yes	No		

ALLEGED FATHER							
Last Name	First Name	M.I					
Address	City	State	Zip				
D.O.B. / /		Last Four Social Security # XXX-XX-	Medicaid #				
Ethnicity:	Caucasian	Black	American Indian	Puerto Rican	Chinese	Mexican American	Filipino
Other (Specify)	Mix (Specify race and %)						
Blood Transfusion in the past 90 days:	Yes	No	Have you ever in your life had a bone marrow transplant :	Yes	No		

* If a paternity test is not performed for the purposes of Tulalip Tribes Enrollment or Tulalip Court Ordered, the client(s) will need to provide a fee of twenty-five (\$25.00) dollars per person to test. [i.e. Baby and Dad would cost \$50.00].
 We do not carry cash, need exact change *

Paternity Testing Form



RELEASE OF PATERNITY TESTING RESULTS

AUTHORIZATION TO DISCLOSE PATERNITY TEST RESULTS OF:			
(FATHER NAME) LAST	FIRST	MIDDLE	DATE OF BIRTH AND LOCATION
PROGRAM CASE NO.	OTHER IDENTIFICATION NUMBER		
(CHILD'S NAME) LAST	FIRST	MIDDLE	DATE OF BIRTH
<p>I have submitted, or am submitting, to the genetic testing of my DNA to determine whether I am the biological father of the above-named child. I hereby authorize the laboratory that performs this DNA analysis to release the results, and any accompanying affidavit regarding the test results, to the Tulalip Tribes beda?chelh, Tulalip Child Support Program and Tulalip Tribal Enrollment Department. I also hereby authorize any one of these three tribal programs that receives my genetic test results to share the results with the other two tribal programs. This information may be provided verbally, or by computer data transfer, mail, fax, or hand delivery. This release is valid for two years from the date signed below. A copy of this form shall be considered as valid as the original. I acknowledge that if I am determined to be the father of the child, that the tribal agency will move to amend the birth certificate in court; I waive notice of such presentment to establish paternity in a court of law.</p>			
LABORATORY NAME		LABORATORY CASE NUMBER (IF KNOWN)	
LABCORP			
PRINT NAME	WITNESS/NOTARY PUBLIC (SIGN & PRINT NAME, IF APPLICABLE)		
<p>If I am not the person who is the subject of this release of paternity test results, I am authorized to sign this release on that person's behalf because I am the: (attach proof of authority)</p> <p style="text-align: center;"> Parent of minor Legal Guardian/Custodian Attorney/Legal Representative </p> <p>Other: _____</p>			

I understand that my records are protected under the federal and state confidentiality regulations (42 CFR, Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA, 45 CFR, part 164). I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I further acknowledge that the information to be released has been fully explained to me and this consent is given of my own free will. If client is less than 13 years of age, a parent or legal guardian must sign consent.

OFFICE USE ONLY:

*Test Can Be Completed before Payment is Received HOWEVER results WILL NOT be released until payment is received in full.

PAID AMT: _____

DATE PAID: _____

REC'D BY: _____

Alleged Father Signature	Today's Date
Child's Parent or Guardian Signature	Today's Date

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