

# Patient Removal from Birth Defects Information System

In accordance with K.S.A. 65-1,244, this form is to permit the removal of child's information from the Kansas Birth Defects Information System. At the parent's/guardian's request, "the individual providing the [removal] form shall discuss with the child's parents or legal guardians the information contained in this system... On receipt of the signed form, the secretary shall remove from the system any information that identifies the child." Information removed will include child's name, parents' names and current addresses, and attending birth physician's name.

SEND COMPLETED REMOVAL FORM FOR BIRTH DEFECTS INFORMATION SYSTEM TO:

**BIRTH DEFECTS SURVEILLANCE PROGRAM  
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT  
1000 SW JACKSON, STE. 220  
TOPEKA, KS 66612-1274**

I) CHILD'S NAME \_\_\_\_\_ -

\_\_\_\_\_ Last, First Middle

II) CHILD'S DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

III) CHILD'S SEX  Male  Female

IV) If child is from a MULTIPLE BIRTH , which child is being re moved from this system ?

First  Second  Third Other \_\_\_\_\_

V) NAME OF CHILD'S BIRTH HOSPITAL/CENTER \_\_\_\_\_

VI) CITY OF BIRTH HOSPITAL/CENTER \_\_\_\_\_

VII) MOTHER'S NAME \_\_\_\_\_ (MAIDEN)  
Last, First Middle

VIII) BIRTH RESIDENT ADDRESS \_\_\_\_\_  
City Address

\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_  
County State Zipcode

**IX) CURRENT ADDRESS**

\_\_\_\_\_|\_\_\_\_\_  
City Address

\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_  
County State

Zipcode

**X) MOTHER'S DATE OF BIRTH** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

**XI) PARENT/GUARDIAN'S SIGNATURE** \_\_\_\_\_

**XII) RELATIONSHIP TO CHILD** \_\_\_\_\_

**XIII) DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

**XIV) PHONE NUMBER (        ) \_\_\_\_\_ — \_\_\_\_\_**