# Florida Sickle Cell Registry
# Opt-In Form

This form is required to opt into the Florida Sickle Cell Registry, allowing the collection of sickle cell screening information, as well as protected health information (PHI) such as medical and treatment information.

By completing this form, I request to be included in the Florida Sickle Cell Registry. I understand that by taking this action, all my sickle cell screening information and other PHI will be added to the registry.

**Name of Individual**:

Last Name: _____ Middle Initial: _____ First Name: _____

**Date of Birth (MM/DD/YYYY):** _____ **Sex:** M (male) ☐ F (female) ☐

**Parent or Guardian (if applicable):**

Last Name: _____ Middle Initial: _____ First Name: _____

**Telephone Number:** _____

**Street Address:** _____, Apt/Unit/Suite: _____

City: _____ State: _____ ZIP: _____

I understand that by signing this form, my sickle cell screening information and other PHI will be kept in the Florida Sickle Cell Registry until I decide to opt out of the registry.

_____ _____

Requestor Signature/Parent or Guardian Signature Date Signed

Please complete this opt-in form and email or mail it to:

**Email:** info@scdregistry.org

**Mailing Address:**

FSCDR
Attn: Florida Sickle Cell Registry
1685 South State Road 7, Unit 4
Hollywood, FL 33023

**Phone:** 844-446-5744

Complete this opt-in form online at https://scdregistry.org/
For more information about the Sickle Cell Registry, please visit https://scdregistry.org/