State of New Jersey
DEPARTMENT OF HEALTH
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MIKIE SHERRILL
Governor

DR. DALE G. CALDWELL
Lt. Governor

www.nj.gov/health

DR. RAYNARD E. WASHINGTON
Acting Commissioner

NEWBORN SCREENING RECORDS RELEASE AUTHORIZATION

(all information is required)

FOR CHILDREN BORN IN NEW JERSEY ONLY

I hereby authorize the New Jersey Department of Health's Newborn Screening Laboratory to release the newborn screening laboratory results for

_____ to:
(Print Full Name of Patient)

_____
(Physician)

_____
(Address)

_____
(Phone Number)

_____
(Email Address)

_____
(Fax Number)

Hospital of Birth: _____

Date of Birth: _____ Sex at Birth: MALE FEMALE

Multiple Birth: NO YES (If yes, list A, B, C, etc.)

Mother's First, Last, and **Maiden** Name_____

This form **must** be completed by patient (if 18 or older) or legal guardian (if 17 or under).
This form was completed by:

Name (print) _____

Phone Number _____ Email_____

Signature _____ Date _____

Contact information of the individual completing this form is asked for if we have questions or are in need of additional information in order to locate newborn screening records. **Form must be sent as a PDF document.** Requests are processed in the order they are received.

Please fax completed form to 609-530-8373 or email to njnbs.results@doh.nj.gov