State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 371
TRENTON, N.J. 08625-0371
www.nj.gov/health

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

JUDITH M. PERSICHILLI, RN, BSN, MA
Commissioner

NEWBORN SCREENING RECORDS RELEASE AUTHORIZATION

(all information is required)

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

____ to:
(**Print** Name of Patient)

____
(Physician)

____
(Address)

____
(City, State and Zip code)

____
(Phone Number)

____
(Fax Number)

Hospital of Birth: ___________________________,

Date of Birth: ____________________, Gender: MALE FEMALE

Mother's First, Last, and Maiden Name___________________________

This form was completed by:
(**Note: if the patient is 18 years of age or older, they must complete and sign this form**)

Name (print) ______________________________________

Phone Number ____________________ Email __________________________

Signature ____________________________, Date _____________

Contact information of the individual completing this form is asked for in the event that we have questions or are in need of additional information in order to locate newborn screening records.

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