State of New Jersey
DEPARTMENT OF HEALTH
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MIKIE SHERRILL
Governor

DR. DALE G. CALDWELL
Lt. Governor

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 or Athletic Department)

_____
(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