



CONSENT FOR MENTAL HEALTH RECORDS SEARCH

This consent **MUST** be completed by the firearm applicant.
Failure to consent requires denial or disapproval of the application.



N.J.S.A. 30:4-24.3 provides that all records of any individual's commitment to a non-correctional institution for mental health reasons shall be confidential and shall not be disclosed except in limited circumstances or with the consent of the individual.

PART ONE (To be completed by the applicant)

Name: (Last, Maiden, First, MI)		Date of Birth: (Month, Day, Year)	Social Security Number
Address: (Number & Street)	(Municipality) ...	(County)	(State)

List Prior Addresses for past 10 years: NOT APPLICABLE

ADDRESS 1: Dates Resided From: _____ To: _____
(Number & Street) (Municipality) (County) (State)

ADDRESS 2: Dates Resided From: _____ To: _____
(Number & Street) (Municipality) (County) (State)

I, _____ am aware of my rights under N.J.S.A. 30:4-24.3, and the Health Insurance Portability and Insurance Accountability Act (HIPAA), 45 C.F.R. 164.50, and consent to the disclosure of my mental health records to the Chief of Police and the Superintendent of State Police, or their designees, for the purpose of verifying my firearms permit application and my fitness to own a firearm under N.J.S.A. 2C:58-3. I understand that copies of this authorization shall be considered sufficient authorization for the release of records.

Investigating Police Department: _____ Witness: _____

X
Signature of Applicant _____ Date _____

The disclosure of my Social Security Number is voluntary. Without this number, the processing of my application may be delayed. This number is considered confidential.

PART TWO (To be completed by County Adjuster's Office, Mental Health Institution and/or Doctor)

Record of Admission: _____ Date of: _____ Signature of Authorized _____
Commitment or Treatment: _____ Check: _____ Official or Doctor: _____

County Adjuster's Office Yes No

Institution or Doctor: Yes No

PART THREE (To be completed by authorized official or doctor only if applicant has record of admission, commitment, or treatment at a hospital, mental institution or sanitarium for a mental disorder)

NAME OF HOSPITAL, MENTAL INSTITUTION OR SANITARIUM	ADMISSION (mo/day/yr)	DISCHARGE (mo/day/yr)	SIGNATURE OF AUTHORIZED OFFICIAL OR DOCTOR
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_____ to _____
_____ to _____