State of New Jersey
DEPARTMENT OF HEALTH
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PHILIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

KAITLAN BASTON, MD, MSC, DFASAM
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 in the event that 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