State of New Jersey
DEPARTMENT OF HEALTH
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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 or Athletic Department)

_____
(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