



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, Full Middle Name) Gender Date of Birth: (Month, Day, Year) Social Security #: *See Privacy Act Notice Below.

Have you been known by any additional names, aliases or maiden names other than the above? If yes, indicate below. If no, write "Not Applicable"

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, including disclosure of the fact that said records may have been expunged, 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 or for the disclosure of the fact of expungement.**

Investigating Police Department

Witness (Print Name)

X

Signature of Witness

X

Signature of Applicant

Date

* Applicant's Social Security Number is requested pursuant to N.J.S.A. 2C:58-3(e) and disclosure is voluntary. The number will be used to expedite the application. Without this number, the processing of the 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)

Please check the appropriate box:

- ☐ No Record
☐ Involuntary Commitment
☐ Voluntary Admission
☐ Record Expunged / Date: _____
☐ Evaluation Only (No Commitment or Admission)
☐ Other

Date of Record Search:

County Adjuster's Office, Institution, and/or Doctor
(Dr.: Provide Medical License #)

X

Print Name

Signature

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

_____ to _____

_____ to _____

CONSENT FOR MENTAL HEALTH RECORDS SEARCH, continued

PART ONE (To be completed by the applicant), continued

Name: (Last, Maiden, First, MI) _____		Gender _____	Date of Birth (Month-Day-Year) _____	Social Security #: *See Privacy Act Notice below. _____
Address #: <u> 3 </u> <i>From:</i> _____ <i>To:</i> _____ (Number & Street) (Municipality) (County) (State)				
Address #: <u> 4 </u> <i>From:</i> _____ <i>To:</i> _____ (Number & Street) (Municipality) (County) (State)				
Address #: <u> 5 </u> <i>From:</i> _____ <i>To:</i> _____ (Number & Street) (Municipality) (County) (State)				
Address #: <u> 6 </u> <i>From:</i> _____ <i>To:</i> _____ (Number & Street) (Municipality) (County) (State)				
Address #: <u> 7 </u> <i>From:</i> _____ <i>To:</i> _____ (Number & Street) (Municipality) (County) (State)				
Address #: <u> 8 </u> <i>From:</i> _____ <i>To:</i> _____ (Number & Street) (Municipality) (County) (State)				
Address #: <u> 9 </u> <i>From:</i> _____ <i>To:</i> _____ (Number & Street) (Municipality) (County) (State)				
Address #: <u> 10 </u> <i>From:</i> _____ <i>To:</i> _____ (Number & Street) (Municipality) (County) (State)				