CLEAR FORM

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 (Print Name)

X _____
Signature of 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 Commitment or Treatment	Date of Check	Signature of Authorized Official or Doctor *(Dr.: Provide Medical License #)*
_____ *County Adjuster's Office*	☐ **Yes** ☐ **No** ☐ **Expunged**	_____	_____
_____ *Institution or Doctor*	☐ **Yes** ☐ **No** ☐ **Expunged**	_____	_____

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 _____	_____

Additional forms may be obtained through the New Jersey State Police, Firearms Investigation Unit, P.O. Box 7068, West Trenton, NJ 08628-0068, or via the internet at www.njsp.org/info/forms.html.