FOR MORE THAN TWO PRIOR ADDRESSES, PLEASE USE ADDITIONAL FORM **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 #:** **See Privacy Act Notice below.*

Current Address: *(Number & Street)*	*(Municipality)*	*(County)*	*(State)*

List Prior Addresses for the past 10 years: ☐ **NOT APPLICABLE**

Address #: 1 *From:* _____ *To:* _____

(Number & Street)	*(Municipality)*	*(County)*	*(State)*

Address #: 2 *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)*

	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		