

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 app	olicant)											
Name: (Last, Maiden, First, Full Middle Name)		Gender Date of Birth: (Month,		lonth, Day, Year	Social Security #: *See Privacy Act Notice Belo							
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)		(Co	unty)	(State)						
List Prior Addresses for past 10 years: NOT APPLICABLE												
ADDRESS 1: Dates Resided From: To:												
(Number & Street)		(Municipality)		(Co	unty)	(State)						
ADDRESS 2: Dates Resided From:												
(Number & Street)		(Municipality)		(Co	unty)	(State)						
I,												
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 O	ffice, M	ental Health I	nstitution a	nd/or Doctor)							
Please check the appropriate box: No Record Involuntary Commitment Voluntary Admission	Date of Record											
Record Expunged / Date:	County Adjuster's Office, Institution, and/or Doctor (Dr.: Provide Medical License #)											
Evaluation Only (No Commitment or Admission)	<u>X</u>											
☐ Other		Print Nan			Signat							
PART THREE (To be completed by auth commitment, or treatment	orized official t at a hospital	or doc menta,	tor only if app I institution or	olicant has r r sanitarium	ecord of adm I for a mental	ission, disorder)						
NAME OF HOSPITAL, MENTAL INSTITUTION OR SANITARIUM	ADMISSIC (mo/day/yi		DISCHARGE (mo/day/yr)		URE OF AUTHO AL OR DOCTOR							
		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)	ocial Security #: *See Privacy Act Notice below.						
	-	-									
Address #:	From:	10:	To:(Municipality)				(State)				
(Number & Street)		(Municip	Municipality)			(County)					
Address #: 4	From:	То:					·				
(Number & Street)		(Municiț	To:(Municipality)			(County)					
Address #- 5	From:	To:									
(Number & Street)	From:	10	To:(Municipality)			nty)	(State)				
(Namoer & Street)		(Maincip	(минстринту)		Cour	ny)	(State)				
Address #:6	From:	То:									
(Number & Street)		(Municiț	To:(Municipality)			(County)					
Address #: 7	From:	То:									
(Number & Street)		(Municiț	To:(Municipality)		(Cour	nty)	(State)				
Address #: 8	From:	То:			1						
(Number & Street)		(Municiț	pality)		(Cour	nty)	(State)				
Address #: 9	From:	То:									
(Number & Street)		(Municip	pality)		(Cour	nty)	(State)				
							1				
	From:										
(Number & Street)		(Municiț	pality)		(Cour	nty)	(State)				
-		•			•						