AUTHORIZATION FOR RELEASE OF INFORMATION

Applicant Name, (Last, First, Middle Initial

.....

Sex ..... Date of Birth .....

SSN REQUIRED

...../...../.....

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed:

Purpose or Need for Information:

The Purpose of the disclosure is; (please check one)

Firearms/Pistol Application Background Check

Explosives Application Background Check

Employment Background Check

From: Central Files

New York State Office of Mental Health
44 Holland Ave. Albany NY 12229

To: Name, Address, & Title of Person/Organization/Facility/ Program to Which this Disclosure is to be Made

NOTE: *If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.*

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I understand that:

1. Only the information described in this form may be used and/or disclosed as a result of this authorization.
2. **ALL of this** information is confidential and is protected under federal privacy regulations (HIPAA) and the NYS Mental Hygiene Law and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with HIPAA, then it could be redisclosed and would no longer be protected by HIPAA. However, this information will still be protected under the NYS Mental Hygiene law, which prohibits this information from being redisclosed by anyone who receives it unless the redisclosure is permitted by the NYS law (Mental Hygiene Law §33.13).
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on this form. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.

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AUTHORIZATION FOR RELEASE OF INFORMATION

Law Enforcement Agency Information to be disclosed to:	**Applicant Name (Last, First, M.I.)**	**PP, EX, EMP,** **(Circle 1)**

B One- Time Use/Disclosure: I hereby permit the one-time use or disclosure of the information described above to the person/ law enforcement agency identified above.

My authorization will expire:

- ❑ When acted upon;
- ❑ 90 Days from this Date;

C. Applicant Signature: I certify that I authorize the use of my information as set forth in this document.

Signature of Applicant or Personal Representative (Handwritten in ink, electronic NOT accepted) _____ Date _____

Applicant's Name (Printed) _____

Personal Representative's Name (Printed) _____

Description of Personal Representative's Authority to Act for the Applicant *(required if Personal Representative signs Authorization)* _____

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the applicant and/or the applicant's personal representative.

WITNESSED BY: _____
Print Name

_____
Signature

Date: _____

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part I, to the Person/law enforcement agency whose name and address is:

_____

_____

_____

I hereby refuse to authorize the use/disclosure indicated in Part I, to the Person/law enforcement agency whose name and address is:

_____

_____

_____

Signature of Applicant or Personal Representative _____ Date _____

Applicant's Name (Printed) _____

Personal Representative's Name (Printed) _____

Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Revocation of Authorization)* _____