NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

EMPLOYEE HEALTH SERVICE
Authorization for Release and Disclosure of Medical Information to a State Agency

EHS-742.4 (4/2018 L)

(Please Print Clearly)	**INFORMATION CONCERNING**		
Last Name	First Name	M.I.	Social Security #
Street Address			
City or Post Office	State	Zip Code	

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION - The information you provide on this form is being requested for the principal purpose of conducting a physical, medical and/or mental evaluation and securing your permission to report our findings to a governmental agency or department. The information will be used in accordance with section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (a) (b), (e) and (f). Failure to provide the information may interfere with our ability to perform such evaluation and report our findings. This information will be maintained by the Director, Employee Health Service, Department of Civil Service, 55 Mohawk Street – Suite 201, Cohoes, NY 12047; telephone (518) 233-3100. For information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF PHYSICAL, MEDICAL AND/OR PSYCHIATRIC INFORMATION TO APPROPRIATE AGENCY

I, _____, authorize the Department of Civil Service to send the following medical records:
(Print Client's Name)

- ☐ Any and all medical information and/or records
- ☐ EHS medical/nursing records of: _____ (***Date(s)***

TO: ***(Please check appropriate box(s)***

- ☐ _____
  (Print Name and Address of State Agency)
- ☐ Department of Correctional Services, Building 2, State Campus, Albany, NY 12226
- ☐ Workers' Compensation Board, 111 Livingston Street, Brooklyn, NY 11201
- ☐ State Insurance Fund, 199 Church Street, New York, NY 10007

THESE RECORDS WILL BE USED FOR:

- ☐ Determining your fitness to perform the essential duties of your present or former position or of the position to which you are applying.
- ☐ Determining your functional limitations if you have requested accommodations pursuant to the A.D.A.
- ☐ Determining whether you have suffered any adverse health effects as a result of your workplace exposures and/or your ability to use personal protective gear and/or your ability to participate in various programs and/or training activities.
- ☐ Other:_____

This information may be re-disclosed by the recipient and no longer be protected under federal law.

This authorization expires in 90 days or on: _____. You may revoke this authorization by writing to the EHS Privacy Official at the address at the top of this page unless the EHS has already released or disclosed the information for the purpose(s) noted above. ***Please make sure you receive a copy of this authorization after you sign it.***

Authorized Signature:	**Date:**

Copies: *EHS (White)* *CLIENT (Yellow)*