NEW YORK STATE OF OPPORTUNITY. | Department of Civil Service

Authorization for Release and Disclosure of Medical Information

EHS-742 (6/06)

(Please Print Clearly)	**INFORMATION CONCERNING**			
Last Name	First Name	M.I.	Date of Birth	Social Security #
Street Address	City		State	Zip Code

Personal Privacy Protection Law - The information which you provide on this form is being requested pursuant to Section 82..3 of the Regulations of the Department of Civil Service (President's Regulations) for the principal purpose of processing the release of your medical records (4NYCRR 82.3). This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e), and (f). Failure to provide the information requested may prevent your medical records from being released. This information will be maintained by the Administrator of the Employee Health Service, NYS Department of Civil Service, 55 Mohawk Street - Suite 201, Cohoes, NY 12047. For further information relating *only* to the Personal Privacy Protection Law, call (518) 457-2487. For information concerning this form, please contact the Employee Health Service at (518) 233-3100.

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF MEDICAL INFORMATION

I, _____, authorize release or disclosure of the following medical records:

☐ EHS **Nurse** records of: _____
(Date(s)

☐ EHS **Medical** records of:_____
(Date(s)

☐ Personal Physician's records pertinent to: _____
(Medical Condition)

☐ Other _____

THESE RECORDS WILL BE USED FOR:

☐ My Personal Use

☐ By EHS to Determine Your Ability to Perform the Duties of Your Position

_____ _____
Signature Date

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

This authorization expires is 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.***

SEND RECORDS FROM:	**SEND RECORDS TO:**
☐ Employee Health Service NYS Department of Civil Service 55 Mohawk Street – Suite 201 Cohoes, NY 12047	☐ Employee Health Service NYS Department of Civil Service 55 Mohawk Street – Suite 201 Cohoes, NY 12047
☐ Physician, Hospital, Other	☐ Physician, Attorney, Self, Other
Name	Name
Organization	Organization
Street or PO Box	Street or PO Box
City State Zip Code	City State Zip Code

Copies: **EHS** (white) **EMPLOYEE** (Pink**)** **OTHER** (Yellow)