POLICE DEPARTMENT, COUNTY OF SUFFOLK, N.Y.
ACCREDITED LAW ENFORCEMENT AGENCY

PDCS-5140-1b

Authorization for Release of Health Information
New York State
Department of Mental Health/Department of Mental Hygiene

NAME	_____
	_____
ADDRESS	_____
	_____
	_____
D.O.B.	_____
S.S.#	_____

I, _____, do hereby authorize any member, or representative, of the Suffolk County Police Department to seek the release of all information contained in my records maintained by the New York State Department of Mental Health / Department of Mental Hygiene. Further, I hereby authorize the New York State Department of Mental Health / Department of Mental Hygiene to forward said medical information / records to any member, or representative, of the Suffolk County Police Department.

The requested records are to be forwarded to the Suffolk County Police Department, at my request, and will be used by the Suffolk County Police Department for investigative purposes. I am aware that the information disclosed pursuant to this Authorization may be subject to re-disclosure and would no longer be protected.

The expiration date of this Authorization is two years from the date of my signature.

I understand that I have the right to revoke this Authorization by forwarding written notice of revocation to the Suffolk County Police Department or the medical facility specified above. Also, I am aware that any 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.

I understand that I do not have to sign this Authorization, and that my refusal to sign will not affect my abilities to obtain medical treatment, nor will it affect my eligibility for any benefits. However, I understand that failure to sign this Authorization, or revocation of this Authorization, will affect my eligibility as a candidate for employment with the Police Department. I further understand that I have a right to inspect and copy my protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found in 45 CFR Section 164.524, and NYS Mental Hygiene Law Section 33.13).

I certify that I authorize the use of my health information as set forth in this document.

_____ Dated: _____
Signature of Patient

_____
Name of Patient (Printed)

Sworn to before me on _____, 20___ Witnessed by:

_____ _____
Notary Public