Office of the Sheriff
County of Madison

Todd M. Hood, Sheriff — James Quatrone, Undersheriff

GUNSMITH/GUN DEALER LICENSING REQUIREMENTS & INSTRUCTIONS

- **You must be at least 21 years of age** (You may be under 21 years of age if possess an Honorable Discharge from Military Service.)
- **You must be a resident of Madison County** for at least the last **6 months.**
- **You must possess one** of the following forms of proof showing your knowledge of the safe handling of firearms:
  - ✓ Hunting License
  - ✓ Hunter's Safety Certificate *(Not Bow Hunting)*
  - ✓ Pistol Safety Course *(On-line Only courses are **not** accepted)*
  - ✓ Military DD-214 *(Honorable and General Under Honorable Discharge)*
  - ✓ Current Active-Duty Military ID
  - ✓ Current or Retired Law Enforcement ID

  (If you are not sure if you meet the requirements, contact (315) 366-2426 for verification)

YOU, THE APPLICANT, DO NOT SIGN ANY FORMS BEFORE YOUR INTERVIEW

After completing the application:

- Contact (315) 366-2406 to schedule your interview.
- Please allow 45-60 minutes for your interview.
- Bring the following to your interview:

  - ✓ **Completed application packet. You will sign as applicant at your appointment.**
  - ✓ **Proof of Knowledge of Safe Handling** of a firearm
  - ✓ **ONE 2" x 2" photo** (Passport size) taken within 60 days of your appointment. This can be obtained anywhere passport photos are taken. Selfies are NOT acceptable.
  - ✓ **Current photo ID.** NYS Driver's License or NYS Non-Driver ID (if you do not possess a NYS Driver's License.) No other photo ID is acceptable.

  - ✓ **Total Application fee of $107.00 payable by cash or money order made payable to Madison County Sheriff's Office OR credit card.** ***A small surcharge is added for all debit and credit card payments.***

    Those currently licensed as a gunsmith/dealer must renew their license every 3 years and reapply every 6 years. The 3-year renewal does not require fingerprinting, so the application fee is $20.00.

FAILURE TO BRING ANY OF THE ABOVE WILL REQUIRE RE-SCHEDULING YOUR APPOINTMENT.

If you are unable to keep your appointment, please call (315) 366-2406 to cancel or reschedule. Late arrivals will require re-scheduling for another date.

More detailed instructions for the application section follow. If you have any questions, please feel free to call the office or email us at pistolpermits@madisoncounty.ny.gov.

Rev 2/2023

YOU, THE APPLICANT, DO NOT SIGN ANY FORMS BEFORE YOUR INTERVIEW

- **BLACK INK ONLY** if handwritten. If using computer, any highlighted field is fillable.
- **Incomplete or Missing forms** will require you to re-schedule for a later date and return with the corrected forms/information.

PPB-6 NEW YORK STATE APPLICATION FORM Pages 3 and 4. **ONE** original is required. ***If you print this packet yourself, please print this set of pages separately in DUPLEX (front & back) format.*** **You need ONE original PPB-6 printed front and back.**

- **DO NOT WRITE ABOVE the Federal Privacy Act Disclaimer (gray area). Office use only.**
- **Complete the forms to the best of your ability. Be as through as possible.**
- **In the "Reason for License" section,** in your own words, please state the reasons you are applying for a pistol permit.
- **YOUR FOUR CHARACTER REFERENCES MUST SIGN THE PPB-6 ORIGINAL.**

Your Personal Character References:

- **MUST** be over the age of 21
- **MUST** be New York State Residents you have known for at least **one** year
- **NO** employees of the Office of the Sheriff of Madison County
- **NO** Relatives or In-laws
- **CANNOT** reside with you or be related to another reference
  (Questions on References please call (315) 366-2426 for clarification)
- Each of your four (4) character references **must sign the** PPB-6 form.

Arrests: Please complete to the best of your knowledge. We understand that there are only two spaces for arrests on this form, use an additional blank sheet of paper if necessary. **You must disclose any and all arrests** (except Violation Level Traffic Offenses) including DWI/DWAI/Driving While Impaired by Drugs or other forms of arrest for operating while intoxicated/impaired (boating, snowmobiling, ATV), juvenile arrests handled by Family Court, adjudicated as a Youthful Offender, charges that were dismissed and sealed arrests. Arrests can be in many different forms including summary arrests/warrant arrests (taken into custody), and arrest by appearance ticket or criminal summons directing you to appear in court at a specified date. Failure to disclose will most likely result in the denial of your application.

You will undergo various background checks by NYS, FBI, and local police agencies where you currently reside, or have in the past. Any additional fees required by these agencies for the background checks are your responsibility. If additional fees are required, you will be notified by our office in writing with instructions for submitting payment.

GUNSMITH APPLICATION CHARACTER REFERENCE INFORMATION Page 5. Use this form to provide more detailed contact information about your character references.

QUESTIONNAIRE and AFFIDAVIT Pages 6-9. Complete as thoroughly as possible. Some of this information has already been requested on the NYS application PPB-6, please include it here also.

INFORMATION RELEASES Pages 10-14.
Information Release: Complete Name, Date of Birth and SSN boxes **ONLY**
Health Information Release forms: There are **three different (3) forms**; State Mental Health, Madison County Mental Health and Family Counseling services. Complete Name, DOB, SSN, and Address **ONLY,** (top section of the form).

PUBLIC RECORDS EXEMPTION FORM Page 15. Complete Name, DOB & Address **ONLY** (top section of the form). This form determines how your personal information is protected in the event of a FOI (Freedom of Information) request.

do not write above this

In accordance with the Federal Privacy Act of 1974, you are hereby notified that your Social Security Number is not mandated by law. It is required by the Pistol Permit Bureau as part of the standard for recording Firearms. Failure to disclose your Social Security Number will prohibit your transaction from being recorded. The State Police will release your Social Security Number only for reasons required by law or with your written consent.

INSTRUCTIONS: **Print or Type in black ink only**

NYSID NUMBER

LICENSE NUMBER

DATE OF ISSUE — MONTH | DAY | YEAR

PPB-6 (REV. 03/11)

STATE OF NEW YORK

APPLICATION FOR LICENSE AS GUNSMITH –DEALER IN FIREARMS

ORIGINAL APPLICATION ☐ **RENEWAL** ☐

COUNTY OF ISSUE — CODE

EXPIRATION DATE — MONTH | DAY | YEAR

LAST NAME | FIRST NAME | MI | DATE OF BIRTH (MONTH | DAY | YEAR) | SEX

RESIDENCE ADDRESS | CITY/VILLAGE/TOWN AND STATE IF OTHER THAN NEW YORK | ZIP CODE

HGT (ins) | WGT (lbs) | EYES | HAIR | RACE | SOCIAL SECURITY NUMBER | PRESENT OCCUPATION | CITIZEN OF U.S.A. ☐ YES ☐ NO

EMPLOYED BY | NATURE OF BUSINESS | BUSINESS ADDRESS

I HEREBY APPLY FOR A LICENSE AS : GUNSMITH ☐ **DEALER IN FIREARMS** ☐ — CHECK ONE OR BOTH AS APPLICABLE — TO CONDUCT BUSINESS AT

STREET ADDRESS OR OTHER LOCATION | CITY, VILLAGE, TOWN | ZIP CODE | BUSINESS TELEPHONE

IS THIS APPLICATION FOR: INDIVIDUAL ☐ FIRM ☐
COMPANY ☐ CORPORATION ☐ PARTNERSHIP ☐

NAME OF FIRM, COMPANY, CORPORATION OR PARTNERSHIP:

GIVE FOUR CHARACTER REFERENCES WHO BY THEIR SIGNATURE ATTEST TO YOUR GOOD MORAL CHARACTER

LAST, FIRST, MI	STREET ADDRESS	CITY, VILLAGE, TOWN	SIGNATURE

HAVE YOU EVER BEEN ARRESTED, SUMMONED, CHARGED OR INDICTED ANYWHERE FOR ANY OFFENSE, INCLUDING DWI (EXCEPT TRAFFIC INFRACTIONS)? ☐ **YES** ☐ **NO** **IF YES, FURNISH THE FOLLOWING INFORMATION:**

DATE	POLICE AGENCY	CHARGE	DISPOSITION - COURT AND DATE

HAVE YOU EVER BEEN TERMINATED/ DISCHARGED FROM ANY EMPLOYMENT OR THE ARMED FORCES FOR CAUSE?	☐ **YES**	☐ **NO**
HAVE YOU EVER UNDERGONE TREATMENT FOR ALCOHOLISM OR DRUG USE?	☐ **YES**	☐ **NO**
HAVE YOU EVER SUFFERED ANY MENTAL ILLNESS, OR BEEN CONFINED TO ANY HOSPITAL, PUBLIC OR PRIVATE INSTITUTION, FOR MENTAL ILLNESS?	☐ **YES**	☐ **NO**
HAVE YOU EVER HAD A PISTOL LICENSE, DEALER'S LICENSE, GUNSMITH LICENSE, OR ANY APPLICATION FOR SUCH A LICENSE DISAPPROVED, OR HAD SUCH A LICENSE REVOKED OR CANCELLED?	☐ **YES**	☐ **NO**
DO YOU HAVE ANY PHYSICAL CONDITION WHICH COULD INTERFERE WITH THE SAFE AND PROPER HANDLING OF A FIREARM?	☐ **YES**	☐ **NO**
HAVE YOU EVER BEEN CHARGED, PETITIONED AGAINST, A RESPONDENT, OR OTHERWISE BEEN A SUBJECT OF A PROCEEDING IN FAMILY COURT?	☐ **YES**	☐ **NO**

IF ANSWER TO ANY QUESTION IS YES, EXPLAIN HERE:

PHOTOGRAPH OF APPLICANT TAKEN WITHIN 30 DAYS

_____

FULL FACE ONLY

ANY OMISSION OF FACT OR ANY FALSE STATEMENT WILL BE SUFFICIENT CAUSE TO DENY THIS APPLICATION AND CONSTITUTES A CRIME PUNISHABLE BY FINE, IMPRISONMENT, OR BOTH.

I AM AWARE THAT THE FOLLOWING CONDITIONS AFFECT ANY LICENSE WHICH MAY BE ISSUED TO ME:

1. NO LICENSE ISSUED AS A RESULT OF THIS APPLICATION IS TRANSFERABLE TO ANOTHER PREMISE, EXCEPT IN ACCORANCE WITH PENAL LAW SECION 400.00 SUBD. 8.
2. ANY LICENSE ISSUED AS A RESULT OF THIS APPLICATION MAY REMAIN VALID DURING ITS TERM PROVIDING THE APPLICANT RETAINS A VALID LICENSE ISSUED PURSUANT TO APPLICABLE FEDERAL LAWS GOVERNING COMMERCE IN FIREARMS.
3. ANY LICENSE ISSUED AS A RESULT OF THIS APPLICATION IS SUBJECT TO REVOCATION AT ANY TIME BY THE LICENSING OFFICER OR ANY JUDGE OR JUSTICE OF A COURT OF RECORD.
4. NO LICENSE ISSUED AS A RESULT OF THIS APPLICATION AUTHORIZES POSSESSION OF FIREARMS OFF OF THE BUSINESS PREMISES INDICATED HEREIN, EXCEPT IN ACCORDANCE WITH PENAL LAW SECTION 400.00. SUBD 8.

JURAT:

SIGNED AND SWORN TO BEFORE ME

THIS _____ **DAY OF** _____ **, 20** ____

AT _____ **, NEW YORK**

_____
SIGNATURE OF APPLICANT

_____
SIGNATURE OF OFFICER ADMINISTERING OATH

_____
TITLE OF OFFICER

THIS FORM APPROVED BY SUPERINTENDENT OF STATE POLICE AS REQUIRED BY PENAL LAW SECTION 400.00, SUBD. 3.

APPLICATION NOT VALID UNLESS SWORN

IF APPLICANT IS A FIRM OR PARTNERSHIP, THE APPLICATION MUST BE SIGNED AND VERIFIED BY EACH INDIVIDUAL COMPOSING OR INTENDING TO COMPOSE SUCH FIRM OR PARTNERSHIP.

NAME	TITLE	NAME	TITLE
NAME	TITLE	NAME	TITLE

IF THE APPLICANT IS A CORPORATION, THE FOLLOWING INFORMATION IS NECESSARY:

SIGNATURE OF PRESIDENT _____

SIGNATURE OF SECRETARY _____

SIGNATURE OF TREASURER _____

NAME OF CORPORATION _____ DATE AND PLACE OF INCORPORATION _____

LOCATION OF PRINCIPAL PLACE OF BUSINESS _____ (STREET) _____ (CITY) _____ (COUNTY) _____ (STATE)

1. RIGHT THUMB	2. RIGHT FOREFINGER	3. RIGHT MIDDLE FINGER	4. RIGHT RING FINGER	5. RIGHT LITTLE FINGER
6. LEFT THUMB	**7. LEFT FOREFINGER**	**8. LEFT MIDDLE FINGER**	**9. LEFT RING FINGER**	**10. LEFT LITTLE FINGER**

PLAIN IMPRESSIONS TAKEN SIMULTANEOUSLY

LEFT FOUR FINGERS		RIGHT FOUR FINGERS
	THUMBS TAKEN TOGETHER	

IMPRESSIONS TAKEN BY: NAME Jeffery A Williams RANK Deputy SHIELD DATE

APPLICANT'S SIGNATURE AND ADDRESS:

INVESTIGATION REPORT – ALL INFORMATION PROVIDED BY THIS APPLICANT HAS BEEN VERIFIED:

NAME Jeffery A Williams RANK Deputy ORGANIZATION Madison County S. O.

SIGNATURE OF INVESTIGATING OFFICER

THIS APPLICATION IS APPROVED – DISAPPROVED (STRIKE OUT ONE)

TITLE AND SIGNATURE OF LICENSING OFFICER

DUPLICATE OF THIS APPLICATION MUST BE FILED WITH THE SUPERINTENDENT OF STATE POLICE WITHIN TEN DAYS OF DATE OF ISSUANCE AS REQUIRED BY SECTION 400.00, SUBDIVISION 5, PENAL LAW.

Office of the Sheriff
County of Madison

GUNSMITH APPLICATION CHARACTER REFERENCE INFORMATION

Use this form to provide more detailed information about the references listed on the PPB-3 form.

Name of Applicant: _____ Date of birth: _____
(first name, middle initial, last name)

	Reference Name	Mailing Address	Residential Address
1.			
	Phone #		
2.			
	Phone #		
3.			
	Phone #		
4.			
	Phone #		

Office of the Sheriff

BLACK INK ONLY **County of Madison** BLACK INK ONLY

GUNSMITH APPLICANT QUESTIONNAIRE AND AFFIDAVIT

STATE OF NEW YORK)
COUNTY OF MADISON) ss:

The undersigned in support of such application submits the following questionnaire and affidavit:

Full Name _____

Date of Birth _____ Social Security # _____

Residential Address

_____

_____

Mailing Address (if different from residential)

_____

_____

County of Residence _____

Length of time: in County _____ Years _____ Months at Residence _____ Years _____ Months

Home Phone # _____ Cell Phone # _____

Driver's License # _____ State of Issue _____

Place of Birth (City/State) _____

Are you a citizen of the United States? ☐ Yes ☐ No If no, what is your citizenship? _____

Have you ever been known by any other name? ☐ Yes ☐ No

If yes, please state in full each name used or which you have at any time been known, and reasons for such name.

_____

_____

Do you claim any other address as your permanent legal address? ☐ Yes ☐ No

If yes, give other address: _____

Length of time at that address: _____ Years _____ Months

Do you file a New York State Income Tax Form? ☐ Yes ☐ No

If no, are you claimed as a dependent on anyone's Income Tax? ☐ Yes ☐ No

Marital Status: ____ Single ____ Married ____ Widowed ____ Separated ____ Divorced

If married/widowed, please state the date and place of marriage and name/maiden name of spouse:

_____

If you are married and living apart, has your separation been the subject of legal proceedings? ☐ Yes ☐ No

If you have been previously married, state full name of your prior spouse(s) and the date and location where the marital status was terminated: (if additional space is required continue on reverse):

_____

Have you ever been charged, petitioned against, or otherwise been a subject of a proceeding in Family Court?

☐ Yes ☐ No If Yes, give full details (if additional space is required continue on reverse):

_____

_____

_____

BEGINNING WITH YOUR CURRENT ADDRESS, list every permanent and temporary place where you have lived since age of 18. Please provide COMPLETE address and dates you lived there. If additional space is required, continue on reverse.

Example: 123 Main St, Anytown, NY 12345 from 10/2017 to 11/2019

_____

_____

_____

_____

_____

_____

_____

_____

Are you now or have you ever been a member of the Armed Forces of the United States, including National Guard or any of the reserve components? ☐ Yes (list below) ☐ No

Dates of Active Duty: _____

Branch of Service: _____

Date of Discharge: _____

As a member of the Armed Forces, have any charges or proceedings been instituted against you? ☐ Yes ☐ No

Have you ever been a defendant in any court martial? ☐ Yes ☐ No

Have you ever received a medical discharge or administrative discharge for medical reason? ☐ Yes ☐ No

If yes to any of the above, please state the date, the nature of the charge, if any, the facts and disposition of the matter and the location and designation of the military establishment where such proceeding took place.

_____

_____

BEGINNING WITH YOUR CURRENT EMPLOYER, list all employers in the last 10 years where you have been employed, self-employed, or associated with any occupation, business, enterprise, or profession, either part-time or full-time? (ALL PERIODS OF TIME IN THE LAST TEN (10) YEARS PRIOR TO THE DATE OF FILING OF THIS APPLICATION MUST BE COVERED. If additional space is required, continue on reverse.

Employer's Name & Full Address	Nature of Business	Position & Reason for Leaving	From/To (month/year)

The following is a COMPLETE record of all instances in which you were arrested or taken into custody, to include being issued an appearance ticket or a court summons. YOU MUST INCLUDE ANY MISDEMEANOR OR FELONY TRAFFIC ARRESTS AND ANY ARRESTS FOR DWI, DWAI-DRUGS OR DWAI. HAVING BEEN ADJUDGED A YOUTHFUL OFFENDER DOES NOT EXCUSE "FULL DISCLOSURE" OF THE UNDERLYING ARREST. No statute, court order, or legal proceeding expunging the information required herein from any record, or dismissing, vacating or setting aside any arrest, accusation or conviction, or purporting to authorize any person to deny existence of such matters shall excuse less than full disclosure. YOU MUST ANSWER THE QUESTIONS (ATTACHMENT OF LETTERS FROM LAW ENFORCEMENT AGENCIES IN LIEU OF AN ANSWER IS NOT ACCEPTABLE.) If additional space is required, continue on reverse.

Date of Arrest	Court	Nature of Charge	Disposition	Fine Amount $

Have you ever been granted immunity and testified as a witness in any criminal action or criminal proceeding in which you were not a party? ☐ Yes ☐ No

If yes, please state the place(s), the date(s), the names of the Defendant(s), the nature of the action or proceeding(s), the Court(s) and the circumstances.

_____

_____

Some license applications require proof of good moral character, (for example: Restaurant and Bar Liquor Licenses, Retail Store Liquor Licenses, Real Estate Broker, Insurance Broker, Medical, Dental, Legal, Nursing Licenses, Banking, Nursing Home Operator Licenses.)

Please state every application made by you for a position, the procurement of which required proof of good character, which was DENIED. Include the name and address of the authority to whom it was addressed, date application was made, and the reasons for denial.

_____

_____

_____

Have you ever held a license or certificate the procurement of which required a proof of good character and such license or certificate was revoked or suspended? ☐ Yes ☐ No

If yes, as to each such license or certificate, please state the date it was revoked or suspended and the name and address of the issuing and revoking authority. _____

_____

Are you or have you ever been treated for dependency for drugs or alcohol? ☐ Yes ☐ No

If yes, please state the details, including dates. _____

_____

Have you ever been declared legally incompetent? ☐ Yes ☐ No

If yes, please state the details, Court, date and Circumstances: _____

_____

Have you ever received a diagnosis of any form of emotional disturbance, nervous or mental disorder? ☐ Yes ☐ No

If yes, please state the details, including dates._____

_____

Have you ever sought or received treatment, therapy or counseling for any form of emotional disturbance, nervous or mental disorder? ☐ Yes ☐ No

If yes, state the names and address of the psychologist, psychiatrists, or other medical practitioners who treated you.

_____

_____

Please state the names, relationships (e.g., spouse, child) of any persons over the age of 16 years living in the dwelling where you reside and state whether any of them have ever been convicted anywhere of any offense (except traffic infractions), and if they were ever treated for alcohol or drug use, or suffered from any mental illness or confined to any hospital, public or private, for mental illness.

_____

_____

_____

_____

Have you ever held or applied for a gunsmith or dealer license in another state or county? ☐ Yes ☐ No
If yes, please provide county, state and date of application:

_____

_____

_____

Have you ever been denied a gunsmith or dealer license in another state or county? ☐ Yes ☐ No
If yes, please provide county, state and date of denial:

_____

_____

_____

Have you ever had a gunsmith or dealer license revoked in another state or county? ☐ Yes ☐ No
If yes, please provide county, state and date of revoke:

_____

_____

_____

I understand that this questionnaire is a continuing questionnaire, and I must provide fully and correctly the information requested as of the date of my application. I will, therefore, before such licensing, notify the court by filing an amendment to this affidavit as to any change with respect to any matter regarding any information requested herein.

_____, being duly sworn says: (Applicant's Printed Name)

I have read the foregoing questions and have answered the same fully. The answers are complete and true to my own knowledge. I have written the answers, or they have been fully written under my supervision.

NOTICE
(PENAL LAW § 210.45)

In a written instrument, any person who knowingly makes a false statement which such person does not believe to be true has committed a crime under the laws of the State of New York punishable as a "Class A Misdemeanor".

SIGNATURE OF APPLICANT: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

WITNESS NAME/TITLE: Jeffery A. Williams, Deputy

Office of the Sheriff
County of Madison

Todd M. Hood, Sheriff

James Quatrone, Undersheriff

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, do hereby authorize the Veteran's Administration, all branches of the United States Military active and reserve, all law enforcement agencies, all courts (Family, City, County, State, Federal), city, state and federal tax bureaus, welfare and unemployment services, credit bureaus, schools, universities, colleges and institutions, to furnish the Madison County Sheriff's Office with any and all available information and copies of records regarding me in order that they may determine my suitability with regards to issuance and possession of a pistol permit.

I authorize the Madison County Sheriff's Office to make inquiry of my present and past employers regarding my character, integrity and reputation.

NOTE: A photocopy of this authorization shall be considered as effective and valid as the original.

Applicant's DOB: _____ Applicant's SS #: _____

Signature of applicant: _____

Date: _____

Witness Name: Deputy Jeffery A. Williams # 10502

Signature of Witness: _____

Date: _____

P.O. Box 16, WAMPSVILLE, NEW YORK 13163
PHONE: 315-366-2406 FAX: 315-366-2286 www.madisoncounty.ny.gov

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
   NYS Office of Mental Health – Clinical Information Services

8. Name and address of person(s) or category of person to whom this information will be sent:
   County Court Judge of Madison County, Sheriff of Madison County, Investigating Captain, Investigator, office clerk

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☑ Other: summary of treatment

Include: (*Indicate by Initiating*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
❑ At request of individual ☑ Other: pursuant to §400.00(4) of Penal	upon receipt of documents
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
   Madison County Office of Mental Health, ADAPT, Outpatient Clinic

8. Name and address of person(s) or category of person to whom this information will be sent:
   County Court Judge of Madison County, Sheriff of Madison County, Investigating Captain, Investigator, office clerk

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☑ Other: summary of treatment

Include: (*Indicate by Initiating*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
❑ At request of individual ☑ Other: pursuant to §400.00(4) of Penal	upon receipt of documents
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
   Family Counseling Services of Cortland County

8. Name and address of person(s) or category of person to whom this information will be sent:
   County Court Judge of Madison County, Sheriff of Madison County, Investigating Captain, Investigator, office clerk

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☑ Other: summary of treatment

Include: (*Indicate by Initiating*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initiating here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
❑ At request of individual ☑ Other: pursuant to §400.00(4) of Penal	upon receipt of documents
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

NYS Firearms License Request for Public Records Exemption

Pursuant to section 400.00 (5) (b) of the NYS Penal Law

I am: [ ] **an applicant** for a firearms license [ ] **currently licensed** to possess a firearm in NYS

Name _____ Date of Birth_____

Address_____

Firearms License # (if applicable) _____ Date Issued_____

Licensing Authority / County of Issuance or Application _____

I hereby request that any information concerning my firearms license application or firearms license not be a public record. The grounds for which I believe my information should **NOT** be publicly disclosed are as follows: (*check all that are applicable)*

☐ **1. My life or safety may be endangered by disclosure because:**

- ☐ A. I am an active or retired police officer, peace officer, probation officer, parole officer, or corrections officer;
- ☐ B. I am a protected person under a currently valid order of protection;
- ☐ C I am or was a witness in a criminal proceeding involving a criminal charge;
- ☐ D. I am participating or previously participated as a juror in a criminal proceeding, or am or was a member of a grand jury;

☐ **2. My life or safety or that of my spouse, domestic partner or household member may be endangered by disclosure for some other reason explained below:** *(Must be explained in item 5 below)*

☐ **3. I am a spouse, domestic partner or household member of a person identified in A, B, C or D of question 1.**

(Please check any that apply)

A ☐ **B** ☐ **C** ☐ **D** ☐

☐ **4. I have reason to believe that I may be subject to unwarranted harassment upon disclosure.**

5. *(Please provide any additional supportive information as necessary)*

_____

_____

_____

I understand that false statements made herein are punishable as a class A misdemeanor. I further understand that upon discovery that I knowingly provided any false information, I may be subject to criminal penalties and that this request for an exemption shall become null and void.

_____ _____

Signature **Date**

NONCRIMINAL JUSTICE APPLICANT'S PRIVACY RIGHTS

As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for employment or a license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below. All notices must be provided to you in writing.[1] These obligations are pursuant to the Privacy Act of 1974, Title 5, United States Code (U.S.C.) Section 552a, and Title 28 Code of Federal Regulations (CFR), 50.12, among other authorities.

- **You must be provided an adequate written FBI Privacy Act Statement (dated 2013 or later) when you submit your fingerprints and associated personal information. This Privacy Act Statement must explain the authority for collecting your fingerprints and associated information and whether your fingerprints and associated information will be searched, shared, or retained.[2]**
- **You must be advised in writing of the procedures for obtaining a change, correction, or update of your FBI criminal history record as set forth at 28 CFR 16.34.**
- **You must be provided the opportunity to complete or challenge the accuracy of the information in your FBI criminal history record (if you have such a record).**
- **If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the employment, license, or other benefit based on information in the FBI criminal history record.**
- **If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at https://www.fbi.gov/services/cjis/identity-history-summary-checks and https://www.edo.cjis.gov.**
- **If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI by submitting a request via https://www.edo.cjis.gov. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.)**
- **You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.[3]**

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[1] Written notification includes electronic notification, but excludes oral notification.

[2] https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement

[3] See 5 U.S.C. 552a(b); 28 U.S.C. 534(b); 34 U.S.C. § 40316 (formerly cited as 42 U.S.C. § 14616), Article IV(c); 28 CFR 20.21(c), 20.33(d) and 906.2(d).

See Page 2 for Spanish translation.

Privacy Act Statement

This privacy act statement is located on the back of the FD-258 fingerprint card.

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

As of 03/30/2018

See Page 2 for Spanish translation.

FINGERPRINT CHALLENGE RIGHTS NOTICE

Challenging Accuracy of Background Checks

If you believe the results of your background check are not complete or are incorrect, you have an opportunity to complete or challenge the accuracy of the information. NYDFS will afford you a reasonable amount of time to correct or complete your record before a licensing decision is made.

To complete or challenge the accuracy of your record:

In order to resolve inaccuracies with your fingerprint background information, you must submit a formal "challenge request" to revise your Identity History Summary. A challenge request can be made by:

Contacting the New York State Division of Criminal Justice Services (DCJS). The DCJS website contains instructions on how to make a challenge request through the agency. You may call the agency at (518) 485-7675 or submit a request using the address below.

Record Review Unit
Office of Criminal Justice Services
80 Swan Street
Albany, NY 12210
dcjsCriminalJusticeRecords@dcjs.ny.gov

Alternatively, you can submit a challenge request directly to the FBI electronically or in writing. If you choose to submit your request electronically, you can visit the FBI's website at https://www.edo.cjis.gov, and following the steps listed under the "Challenging Your Identity History Summary" section. Written submissions should be sent to:

FBI CJIS Division
Attn: Criminal History Analysis Team I
1000 Custer Hollow Road
Clarksburg, WV 26306

Challenge requests may require the submission of certified court documents. You should contact the respective court prior to submitting a challenge request. Photocopies of these documents are not accepted unless they contain a raised seal placed on the document by the court. The Department will place your application on hold for a period of 45 days. You must submit official Identity History Summary communication from the FBI documenting the correction(s) in your Identity History Summary. Please do not submit photocopies of such documents. Failure to provide documentation will result in the withdrawal or denial of your application.