Duffy, Daniel FOI # 14227

From:
Sent: Wednesday, August 21, 2013 5:20 PM
To: Duffy, Daniel
Cc: Torres Rojas, Genara; Van Duyne, Sheree; Qureshi, Ann
Subject: Freedom of Information Online Request Form

Information:

First Name: Jeffrey
Last Name: Caubet
Company: PATH
Mailing Address 1:
Mailing Address 2:
City:
State:
Zip Code:
Email Address:
Phone:
Required copies of the records: No

List of specific record(s):
I would like to request blank copies of the following forms from the Port Authority Office of Medical Services
1 Authorization to disclose or release medical records, 2 Psychological services program agreement.

THE PORT AUTHORITY OF NY & NJ

FOI Administrator

August 28, 2013

Mr. Jeffrey Caubet

Re: Freedom of Information Reference No. 14227

Dear Mr. Caubet:

This is a response to your August 21, 2013 request, which has been processed under the Port Authority's Freedom of Information Code (the "Code", copy attached) for a copy of Port Authority Office of Medical Services forms for: 1. authorization to disclose or release medical records and, 2. psychological services program agreement.

Material responsive to your request and available under the Code can be found on the Port Authority's website at http://www.panynj.gov/corporate-information/foi/14227-O.pdf. Paper copies of the available records are available upon request.

Please refer to the above FOI reference number in any future correspondence relating to your request.

Very truly yours,

Daniel D. Duffy
FOI Administrator

Attachment

225 Park Avenue South, 17th Floor
New York, NY 10003
T: 212 435 3642
F: 212 435 7555

THE PORT AUTHORITY OF NEW YORK & NEW JERSEY
OFFICE OF MEDICAL SERVICES
PSYCHOLOGICAL SERVICES PROGRAM AGREEMENT

Employee Name: _____

Employee Number: _____

Date: _____

1. I, _____ agree to cooperate with all of the Office of Medical Services (OMS) Psychological Services Program requirements.

   I understand that any failure to cooperate fully with one or more of the program requirements may result in dismissal from the Program and referral for administrative disposition which could result in disciplinary action up to and including termination.

2. The Program requirements that I must fully cooperate with are:

   a. I agree to be evaluated by the Port Authority's Psychological Services professional at the time and location as scheduled.

   b. I agree to fully cooperate and participate in any recommended counseling or treatment program in accordance with the instructions and requirements of the Port Authority Psychological Services professional.

   c. I agree to sign written consent authorizing counseling or treatment representatives to confer with and disclose to the Port Authority's Psychological Services professional or a designated representative all information and records concerning my counseling or treatment.

   d. I agree that once I am returned to duty by the Port Authority's Psychological Services, I will report to duty at the designated worksite at the designated time.

   e. I must successfully complete, if recommended by the Port Authority Psychological Services professional, a treatment program.

   f. I agree to promptly attend each and every scheduled appointment with the Office of Medical Services and/or Psychological Services Program professional staff or other outside treatment facilities. Instances of absence from such scheduled appointments are not permitted unless I can prove that said absence was caused by circumstances clearly and completely beyond my control and that I will provide documentation thereof.

3. I, _____, understand that participation in the Psychological Services Program will not require or result in special privileges or exemptions from the standard administrative practices applicable to required job performance.

_____ _____

Employee Signature Date

_____ _____

Psychological Services Date

NOTE: *All psychological services at the Port Authority are confidential. Psychological records are kept completely separate from all other records. Port Authority Office of Medical Services staff confer with one another as needed to provide integrated care for you. If you are treating with an external provider or facility, the Port Authority psychological professional may share relevant health information for continuity of care. Otherwise, the Port Authority will not release any information about you without your written permission, except as authorized or required by law, or in our judgment as necessary to protect you or others from a serious threat to health or safety or in conjunction with a hearing, arbitration or disciplinary action where you have put your condition into issue.*

THE PORT AUTHORITY OF NY & NJ

OFFICE OF MEDICAL SERVICES
233 PARK AVE. SOUTH, 8TH FLOOR, NEW YORK, NY 10003
TELEPHONE: 212.435.2695/2676 FAX: 212.435.2729

AUTHORIZATION TO DISCLOSE OR RELEASE MEDICAL RECORDS

I hereby authorize the Port Authority Office of Medical Services to _____disclose/release to _____obtain from

_____
(Name of person or organziation) (Telephone No.) (Fax)

_____
(Address) (City) (State) (Zip)

INFORMATION REQUESTED:
[ ] ALL medical records without exception, including clinicial notes, lab testing (including HIV), mental health treatment, alcohol or drug abuse testing and treatment, sexually transmitted disease, consultations, or:

[ ] PARTIAL medical records which may include HIV testing and treatment, mental health treatment, alcohol or drug abuse testing and treatment, sexually transmitted disease and other sensitive information.
Please specify parts and dates to be released:

- ☐ Medical Progress Notes _____
- ☐ Psychological Progress Notes _____
- ☐ X-ray Reports _____
- ☐ Lab Reports _____
- ☐ Drug & alcohol screening tests _____
- ☐ Other (specify) _____
- ☐ Immunizations _____
- ☐ Physicals _____
- ☐ Consultations _____
- ☐ Pre-employment physical results _____

For the purpose of _____

I hereby agree to this authorization and understand that it must contain Personally Identifiable Information and PHI as defined by HIPAA to ensure accuracy. I understand that I have the right to limit the type of information released and to revoke this authorization by submitting a notice, in writing, to the Port Authority Office of Medical Services. Unless revoked, this authorization will expire one year from date of signature or on the following date _____. If I choose to limit the information released, I understand that the Port Authority Office of Medical Services may inform the requestor that portions of the record have been withheld. I understand the information disclosed may be subject to redisclosure by the recipient and no longer be protected by the Port Authority Office of Medical Services. The Port Authority and its staff are hereby released from any legal responsibility or liability for disclosure of the below information to the extent indicated and authorized herein.

I authorize the release of my medical records as indicated above.

_____
(Signature of employee/candidate)

_____
(Employee number - if not PA employee, SSN)

_____
(Print Name)

_____
(Date of Birth)

_____
(Address)

_____
(City, State, Zip)

_____
(Telephone Number)

_____
(Date)

_____
(Previous name under which records may be found)