**KINGSBOROOUGH COMMUNITY COLLEGE**

**of The City of New York**

PERMISSION FOR ACCESS TO EMPLOYMENT RECORDS

This form allows employees to grant third parties access to their employment records, including health and medical records, maintained by the Office of Human Resources.

PLEASE PRINT:

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, THE UNDERSIGNED, HEREBY AUTHORIZE Kingsborough Community College of The City University of New York to release the following employment records and information (identify records or types of records below):

These records should be released to the following person/agency (identify full name and address of person/agency to receive information):

These records are being released for the purpose stated below:

I understand that: 1) this authorization will expire on the day my employment at Kingsborough Community College expires; 2) that I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance on this authorization; and 3) that once this information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient(s), and may no longer be protected by federal and state privacy regulations.

Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ I do not authorize release of any records and information to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Revised 04/18/2016