TOMPKINS COUNTY SHERIFF'S OFFICE
SHERIFF DEREK R. OSBORNE
UNDERSHERIFF JENNIFER K. OLIN

NEW YORK

779 Warren Road
Ithaca, NY 14850

Phone
(607) 257-1345

Fax
(607) 266-5436

PISTOL / SEMI-AUTOMATIC RIFLE LICENSE REQUIREMENTS

Applicant Requirements:

- Must be at least 21 years of age to apply (you may be under 21 if you have been honorably discharged from the military)
- Must reside, be employed in, or have a place of business in Tompkins County
- Must have four (4) character references who:
  - Reside in Tompkins County
  - Are not related to, or live at the same address as you or each other
  - Have known you for at least one year
  - Are at least 21 years of age
  - Will be required to complete a questionnaire and return it to the Tompkins County Sheriff's Office within 30 days.

Applicants for a Carry Concealed Pistol Permit:

- Must provide proof of completion of an approved 18-hour firearm safety training course from a duly authorized instructor as required by New York Penal Law 400.00(19). This includes 16-hours of classroom and 2-hours of live-fire safety training.
- Will be required to have an in-person interview

Applicants for: Possess on Premises AND Semi-Automatic Rifle:

- Firearm safety training course and in-person interview is not required

You CANNOT apply for a permit if:

- You have ever been previously convicted of a felony or a serious offense, as defined by the New York State Penal Law 265.00(17)
- You have been convicted of a misdemeanor level Assault, DWI, or Menacing within the last five (5) years
- The full list of all disqualifying factors and arrests is available on our website.

PISTOL / SEMI-AUTOMATIC RIFLE LICENSE APPLICATION INSTRUCTIONS

1) 18-hour firearm safety training

- Applicants for a Carry Concealed Permit must complete the state mandated 18-hour firearm safety training course (16-hours of classroom and 2-hours of live-fire firearm safety training.

    - The course is **NOT REQUIRED** for a Possess on Premises or Semi-Automatic Rifle Permit

2) Obtain fingerprints - schedule by phone or online. The **service code is: 155TZQ**

- Online - the website is https://uenroll.identogo.com
- By phone - call 877-472-6915. For hearing impaired, call 877-219-0199

    - Note: At your fingerprint appointment, you will be given two (2) receipts. You MUST bring one of the receipts to the Sheriff's Office for your appointment when turning in your application.

3) Complete all enclosed forms

There are detailed instructions for the different sections of the application below:

- Do not sign any forms until you are at the Sheriff's Office. Notaries are available at our office
- Use **black ink ONLY** (must be legible)

OR

- Most of the application packet can be typed on a computer, with the exception of signatures
- Incomplete or missing forms will require you to re-schedule

PPB-3 New York State Application

- Start with the Personal Information Section; please do not write anything above this area
- Fill out **both** of the PPB -3 Applications, following the directions carefully. We cannot accept copies; **both** must be an original

- Character References
    - Each of your character references **must personally sign** both applications, again in **black ink** only and **no copies**

    - See page one (1) for requirements to be a reference

- You must disclose all arrests (except traffic infractions)

    - Including arrests that were dismissed, juvenile status, or sealed by the court. Even if the Court no longer has record of your case because it is very old, they have destroyed the record, or your case was sealed; you still have a criminal record that the Sheriff's Office will have full access to, even if it was an out-of-state arrest.

    - You were arrested if you were (any of the following):
        - Given an appearance ticket to appear before a judge
        - Handcuffed and taken to jail
        - Fingerprinted and photographed for a criminal matter or DWI
        - Directed to turn yourself in, or appear before a Judge because a warrant for arrest was issued for you
        - Directed by a police officer to appear before a Judge

    - ANY OMMISION OR FALSE STATEMENT WILL MOST LIKELY RESULT IN THE DENIAL OF YOUR APPLICATION AND CONSTITUES A CRIME PUNISHABLE BY FINE, IMPRISONMENT OR BOTH

<u>Applicant Questionnaire</u>

- Complete the form in its entirety

<u>Information Release</u>

1. Authorization for Release of Personal Information
    - Complete Name, Date of Birth and Social Security Number boxes only
2. Tompkins County Mental Health Services Authorization for Release of Information
    - Complete Name, Date of Birth, ID (if applicable), and Address (top section of the form) **ONLY**
3. Authorization for Release of Health Information Pursuant to HIPAA
    - Complete Name, Date of Birth, Social Security Number and Address (top section of the form) **ONLY**

NYS Firearms License Request for Public Records Exemption

- Optional - this form gives permit holders the ability to protect their information, such as name and address, being released publicly in the event of a FOIL (Freedom of Information Law) request

    - You are required to check **one** of the boxes #1-4

4) After completing the application - make an appointment with the Tompkins County Sheriff's Office

- Call the Sheriff's Office at 607-257-1345 to schedule an appointment. At your appointment, you will turn in your applications and all additional forms. We will take your photo and obtain your electronic signature for your permit.

Bring the following to your appointment:

- ☐ If applying for a **carry concealed license** you must provide a certificate of completion of the required 18-hour firearm safety training from a duly authorized instructor as required by New York Penal Law 400.00(19)
- ☐ Fingerprinting receipt
- ☐ Completed application packet with original unsigned documents, copies will not be accepted
    - Incomplete or missing forms will require you to re-schedule
- ☐ Four (4) stamped envelopes with your character references names and addresses (one for each reference).
    - Your references will be mailed a questionnaire, which they must return to our office within 30 days.
- ☐ $18.00 CASH ONLY
- ☐ Valid photo ID: Driver's License or Non-Driver ID issued by the Department of Motor Vehicles
    - If you do not live in Tompkins County, you must provide proof of employment or place of business in Tompkins County
    - If you are a part-time resident with an out of state Driver's License you must bring a copy of a current property tax bill
    - If you are under 21 years of age you must provide proof of an honorable discharge
    - If you are not a US Citizen, you must provide a Resident Alien Card

Failure to bring any of the above will require re-scheduling your appointment.

Additional Information

- The processing of a pistol permit application can take up to 12 months, with a majority completed within 6 months
- The Sheriff's Office will conduct a thorough investigation, including interviewing references. Once completed, the investigation findings along with a Deputy's report will be forwarded to a Tompkins County Court Judge for approval or denial. The Sheriff's Office has no authority or decision making in this process but acts as an agent on behalf of the licensing officer.
- If anything changes during the process, including an address change, you must inform our office.
- Applicants will receive notice of approval or denial from the Sheriff's Office by mail.

PPB-3 (Rev 08/22)

Complete the form in its entirety. Fields that are not fillable must be hand written/signed.

State of New York

Pistol/Revolver License Application

Semi-Automatic Rifle License Application

THIS SECTION TO BE COMPLETED BY LICENSING OFFICE

NYSID #	License #	County of Issue
Date of Issue	**Expiration Date**	

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.

Personal Information

Last Name	First Name	Middle Name	Suffix

Street Name (Physical Address)	Apt #	City	State	Zip
Mailing Address (If Different than Physical)	**Apt #**	**City**	**State**	**Zip**

Sex:	DOB:	Height: ft in	Weight:	Hair:	Eyes:

Social Security Number:	Race:	NY Driver's License # (or Non-Driver ID)

Citizen of U.S.	Primary Phone #	Secondary Phone #	Email Address

Employed By	Current Occupation	Nature of Business

Business Address	Apt #	City	State	Zip

I hereby apply for a Pistol/Revolver License to: (Check only one) ☐ **Carry Concealed** ☐ ***Possess on Premises** ☐ ***Possess/Carry During Employment**

(*) Premise Address or Employer Name and Address must be provided below:

Employer Name (If Carry During Employment)	Address or Other Location (Street #, Street Name, Apartment Number, City, State, Zip Code)

I hereby apply for a Semi-Automatic Rifle License: (Check Yes or No) ☐ **Yes** ☐ **No**

Give four character references who by their signature attest to your good moral character:

Last, First, MI	Street Address (Street #, Name, Apartment #, City, State, Zip Code)	Signature

State of New York

Pistol/Revolver License Application

Semi-Automatic Rifle License Application

Marital Status and Relationships-*THIS SECTION ONLY APPLIES TO CARRY CONCEALED*

CURRENT MARRIAGE OR RELATIONSHIP

What is the Applicant's current relationship status?

If applicable, provide the requested information regarding the Applicant's current relationship below.

Last Name	First Name	M.I.	Maiden Name (If Applicable)	DOB

Phone Number

Do minors reside within the residence? ☐ **Yes** ☐ **No** **If, yes:** ☐ **Part Time** ☐ **Full Time**

ADULTS RESIDING IN HOME, INCLUDING ADULT CHILDREN

Last Name	First Name	M.I.	Maiden Name (If Applicable)	DOB

Phone Number

Last Name	First Name	M.I.	Maiden Name (If Applicable)	DOB

Phone Number

Last Name	First Name	M.I.	Maiden Name (If Applicable)	DOB

Phone Number

Social Media Accounts-*THIS SECTION ONLY APPLIES TO CARRY CONCEALED*

LIST FORMER AND CURRENT SOCIAL MEDIA ACCOUNTS FOR THE PAST THREE YEARS

State of New York

Pistol/Revolver License Application
Semi-Automatic Rifle License Application

Have you ever been arrested, summoned, charged or indicted anywhere for any offense, including sealed arrests DWI (except traffic infractions)? Sealed arrests must be included. *Refer to Executive Law §296(16)

☐ **Yes** ☐ **No** **If yes, furnish the following information:**

Arrest Date	Police Agency	Charge	Disposition Date	Disposition Court	Disposition

Are you a fugitive from justice?

Are you an unlawful user of or addicted to any controlled substance as defined in section 21 U.S.C. 802?

Are you an alien illegally or unlawfully in the United States?

Are you an alien admitted to the United States who does not qualify for the exceptions under 18 U.S.C. 922 (y)(2)?

Have you been discharged from the Armed Forces under dishonorable conditions?

Have you ever renounced your United States citizenship?

Have you ever suffered any mental illness?

Have you ever been involuntarily committed to a mental health facility?

Have you ever had a pistol / revolver / semi-automatic rifle license revoked?

Are you under any firearms suspension or ineligibility order issued pursuant to the provisions of section 530.14 of the criminal procedure law or section eight hundred forty-two-a of the family court act?

Have you had a guardian appointed for you pursuant to any provision of state law, based on a determination that as a result of marked subnormal intelligence, mental illness, incapacity, condition or disease you lack the mental capacity to contract or manage your own affairs?

Have you been convicted of Assault 3rd, Misdemeanor DWI, or Menacing 3rd within the previous five years?
THIS QUESTION ONLY APPLIES TO CARRY CONCEALED

Are you prohibited from possessing firearms under federal law, including having been convicted in any court of a misdemeanor crime of domestic violence or being under indictment for a crime punishable by imprisonment for a term exceeding one year?

If the answer to any of the questions above is YES, explain here:

For applicants under twenty-one years of age only:

Have you been honorably discharged from the United States Army, Navy, Marine Corps, Air Force or Coast Guard, or the National Guard of the State of New York?

State of New York

Pistol/Revolver License Application
Semi-Automatic Rifle License Application

Photograph Of Applicant Taken Within 30 Days

_____

Full Face Only

Knowingly providing false information 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 valid in the City of New York.
2. Any pistol/revolver license issued as a result of this application will be valid only for a pistol or revolver specifically described in the license properly issued by the licensing officer.
3. If I permanently change my address, notice of such change and my new address must be forwarded to the Superintendent of the State Police and in Nassau County and Suffolk County, to the licensing officer of that county, within 10 days of such change.
4. 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.

Jurat:
Signed and sworn to me before

This _____ **day of** _____ **, 20** _____

at _____ **, New York**

_____ Signature of Applicant

_____ Signature of Officer Administering Oath

_____ Title of Officer

APPLICATION NOT VALID UNLESS SWORN

Fingerprints submitted electronically by:

Name _____ Rank _____ Organization _____

Date Submitted _____

Investigation Report – All information provided by this applicant has been verified:

Name _____ Rank _____ Organization _____

_____ Signature of Investigating Officer

This application is **Approved** **Disapproved**

_____ Title and Signature of Licensing Officer

The following restriction(s) is (are) applicable to this license:

_____

If Licensing Officer authorizes the possession of a pistol, revolver or single shot firearm(s) at the time of issue of original license, furnish the following information:

******List handguns only, do not list semi-automatic rifles.***

Manufacturer	Pistol/Revolver/ Single Shot	Model	Frame Only	Caliber(s)	Serial Number	Property of
			☐			
			☐			
			☐			
			☐			

Duplicate of this application must be filed with the Superintendent of State Police within 10 days of issuance as required by Penal Law Section 400.00 SUBD.5.

This form is approved by Superintendent of the State Police as required by Penal Law section 400.00, SUBD. 3.

PPB-3 (Rev 08/22)

Complete the form in its entirety. Fields that are not fillable must be hand written/signed.

State of New York

Pistol/Revolver License Application

Semi-Automatic Rifle License Application

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Personal Information

Last Name	First Name	Middle Name	Suffix

Street Name (Physical Address)	Apt #	City	State	Zip
Mailing Address (If Different than Physical)	**Apt #**	**City**	**State**	**Zip**

Sex:	DOB:	Height: ft in	Weight:	Hair:	Eyes:

Social Security Number:	Race:	NY Driver's License # (or Non-Driver ID)

Citizen of U.S.	Primary Phone #	Secondary Phone #	Email Address

Employed By	Current Occupation	Nature of Business

Business Address	Apt #	City	State	Zip

I hereby apply for a Pistol/Revolver License to: (Check only one) ☐ **Carry Concealed** ☐ ***Possess on Premises** ☐ ***Possess/Carry During Employment**

(*) Premise Address or Employer Name and Address must be provided below:

Employer Name (If Carry During Employment)	Address or Other Location (Street #, Street Name, Apartment Number, City, State, Zip Code)

I hereby apply for a Semi-Automatic Rifle License: (Check Yes or No) ☐ **Yes** ☐ **No**

Give four character references who by their signature attest to your good moral character:

Last, First, MI	Street Address (Street #, Name, Apartment #, City, State, Zip Code)	Signature

State of New York

Pistol/Revolver License Application

Semi-Automatic Rifle License Application

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Last Name	First Name	M.I.	Maiden Name (If Applicable)	DOB

Phone Number

Do minors reside within the residence? ☐ **Yes** ☐ **No** **If, yes:** ☐ **Part Time** ☐ **Full Time**

ADULTS RESIDING IN HOME, INCLUDING ADULT CHILDREN

Last Name	First Name	M.I.	Maiden Name (If Applicable)	DOB

Phone Number

Last Name	First Name	M.I.	Maiden Name (If Applicable)	DOB

Phone Number

Last Name	First Name	M.I.	Maiden Name (If Applicable)	DOB

Phone Number

Social Media Accounts-*THIS SECTION ONLY APPLIES TO CARRY CONCEALED*

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State of New York

Pistol/Revolver License Application
Semi-Automatic Rifle License Application

Have you ever been arrested, summoned, charged or indicted anywhere for any offense, including sealed arrests DWI (except traffic infractions)? Sealed arrests must be included. *Refer to Executive Law §296(16)

☐ **Yes** ☐ **No** **If yes, furnish the following information:**

Arrest Date	Police Agency	Charge	Disposition Date	Disposition Court	Disposition

Are you a fugitive from justice?

Are you an unlawful user of or addicted to any controlled substance as defined in section 21 U.S.C. 802?

Are you an alien illegally or unlawfully in the United States?

Are you an alien admitted to the United States who does not qualify for the exceptions under 18 U.S.C. 922 (y)(2)?

Have you been discharged from the Armed Forces under dishonorable conditions?

Have you ever renounced your United States citizenship?

Have you ever suffered any mental illness?

Have you ever been involuntarily committed to a mental health facility?

Have you ever had a pistol / revolver / semi-automatic rifle license revoked?

Are you under any firearms suspension or ineligibility order issued pursuant to the provisions of section 530.14 of the criminal procedure law or section eight hundred forty-two-a of the family court act?

Have you had a guardian appointed for you pursuant to any provision of state law, based on a determination that as a result of marked subnormal intelligence, mental illness, incapacity, condition or disease you lack the mental capacity to contract or manage your own affairs?

Have you been convicted of Assault 3rd, Misdemeanor DWI, or Menacing 3rd within the previous five years?
THIS QUESTION ONLY APPLIES TO CARRY CONCEALED

Are you prohibited from possessing firearms under federal law, including having been convicted in any court of a misdemeanor crime of domestic violence or being under indictment for a crime punishable by imprisonment for a term exceeding one year?

If the answer to any of the questions above is YES, explain here:

For applicants under twenty-one years of age only:

Have you been honorably discharged from the United States Army, Navy, Marine Corps, Air Force or Coast Guard, or the National Guard of the State of New York?

State of New York

Pistol/Revolver License Application
Semi-Automatic Rifle License Application

Photograph Of Applicant Taken Within 30 Days

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Full Face Only

Knowingly providing false information 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 valid in the City of New York.
2. Any pistol/revolver license issued as a result of this application will be valid only for a pistol or revolver specifically described in the license properly issued by the licensing officer.
3. If I permanently change my address, notice of such change and my new address must be forwarded to the Superintendent of the State Police and in Nassau County and Suffolk County, to the licensing officer of that county, within 10 days of such change.
4. 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.

Jurat:
Signed and sworn to me before

This _____ **day of** _____ **, 20** _____

at _____ **, New York**

_____ Signature of Applicant

_____ Signature of Officer Administering Oath

_____ Title of Officer

APPLICATION NOT VALID UNLESS SWORN

Fingerprints submitted electronically by:

Name _____ Rank _____ Organization _____

Date Submitted _____

Investigation Report – All information provided by this applicant has been verified:

Name _____ Rank _____ Organization _____

_____ Signature of Investigating Officer

This application is **Approved** **Disapproved**

_____ Title and Signature of Licensing Officer

The following restriction(s) is (are) applicable to this license:

_____

If Licensing Officer authorizes the possession of a pistol, revolver or single shot firearm(s) at the time of issue of original license, furnish the following information:

******List handguns only, do not list semi-automatic rifles.***

Manufacturer	Pistol/Revolver/ Single Shot	Model	Frame Only	Caliber(s)	Serial Number	Property of
			☐			
			☐			
			☐			
			☐			

Duplicate of this application must be filed with the Superintendent of State Police within 10 days of issuance as required by Penal Law Section 400.00 SUBD.5.

This form is approved by Superintendent of the State Police as required by Penal Law section 400.00, SUBD. 3.

TOMPKINS COUNTY SHERIFF'S OFFICE

PISTOL / RIFLE PERMIT APPLICANT QUESTIONNAIRE & AFFIDAVIT

(please type or print in black ink)

FIRST NAME	M.I.	LAST NAME	SUFFIX

PROVIDE ANY OTHER NAMES EVER USED OR KNOWN BY AND REASON FOR USE:

1. _____ 3. _____

2. _____ 4. _____

ARE YOU A U.S. CITIZEN?

☐ YES ☐ NO: IF NO, PLEASE ATTACH A COPY OF GREEN CARD/PASSPORT/N.Y.S. ID

DATE OF BIRTH	PERSONAL PHONE #	PERSONAL EMAIL ADDRESS
_____/_____/_____		

CURRENT STREET ADDRESS	CITY/TOWN/VILLAGE	ZIP

MAILING ADDRESS IF DIFFERENT SAME AS STREET ADDRESS	CITY/TOWN/VILLAGE	ZIP

LENGTH OF TIME AT CURRENT ADDRESS

_____ YEARS _____ MONTHS ☐ OWN ☐ RENT

OTHER: _____

ARE OTHER HOUSEHOLD MEMBERS AWARE THAT YOU HAVE APPLIED FOR A PERMIT?

☐ YES ☐ NO

IF YOU HAVE BEEN AT YOUR CURRENT ADDRESS LESS THAN 5 YEARS, LIST PREVIOUS ADDRESSES GOING BACK 5 YEARS:

1. _____

2. _____

3. _____

4. _____

STARTING WITH YOUR CURRENT EMPLOYER, LIST ALL EMPLOYERS GOING BACK 5 YEARS:

1. _____ (COMPANY/EMPLOYER NAME), _____ (JOB TITLE), _____ (CITY/TOWN/VILLAGE), _____ (STATE)

2. _____ (COMPANY/EMPLOYER NAME), _____ (JOB TITLE), _____ (CITY/TOWN/VILLAGE), _____ (STATE)

3. _____ (COMPANY/EMPLOYER NAME), _____ (JOB TITLE), _____ (CITY/TOWN/VILLAGE), _____ (STATE)

4. _____ (COMPANY/EMPLOYER NAME), _____ (JOB TITLE), _____ (CITY/TOWN/VILLAGE), _____ (STATE)

HAVE YOU EVER BEEN TERMINATED FROM EMPLOYMENT?

☐ NO ☐ YES: TERMINATING EMPLOYER: _____

REASON: _____

TOMPKINS COUNTY SHERIFF'S OFFICE

PISTOL PERMIT APPLICANT QUESTIONAIRE & AFFADAVIT

(please type or print in black ink)

HAVE YOU EVER BEEN INTERVIEWED BY A LAW ENFORCEMENT OFFICER IN RELATION TO AN INCIDENT OR CRIME (WHETHER AS A SUSPECT, VICTIM, OR WITNESS)? ☐ NO ☐ YES: PLEASE INDICATE WHEN, WHERE, AND WHY AND THE AGENCY INVOLVED:

HAVE YOU EVER BEEN NAMED AS A RESPONDENT OR PETITIONER IN AN ORDER OF PROTECTION?

☐ NO ☐ YES: ☐ PETITIONER ☐ RESPONDENT: PLEASE PROVIDE COURT OF ISSUANCE AND OTHER PARTY INVOLVED:

DO YOU CONSUME ALCOHOLIC BEVERAGES?

☐ NO ☐ YES

IF YES, HAS DRINKING ALCOHOL EVER CAUSED A PROBLEM FOR YOU? ☐ NO ☐ YES

IF YES, DETAIL THE EXTENT OF YOUR ALCOHOL-RELATED PROBLEMS & STEPS TAKEN TO CORRECT IT:

HAVE YOU EVER RECEIVED DRUG OR ALCOHOL COUNSELING?

☐ NO ☐ YES: IF YES, PLEASE PROVIDE DETAILS OF WHEN AND WHERE, AND IF TREATMENT WAS COMPLETED:

HAVE YOU EVER SUFFERED FROM ANY FORM OF MENTAL ILLNESS, OR, HAVE YOU EVER RECEIVED TREATMENT FOR MENTAL ILLNESS, OR BEHAVIORAL /EMOTIONAL CONTROL?

☐ NO ☐ YES: IF YES, PLEASE PROVIDE DETAILS OF WHEN AND WHERE, AND IF TREATMENT WAS COMPLETED:

HAVE YOU EVER ATTEMPTED OR SERIOUSLY CONTEMPLATED SUICIDE?

☐ NO ☐ YES: IF YES, PLEASE EXPLAIN:

TOMPKINS COUNTY SHERIFF'S OFFICE

PISTOL PERMIT APPLICANT QUESTIONAIRE & AFFADAVIT

(please type or print in black ink)

USE THIS SPACE TO CONTINUE WITH ANY RESPONSES TO QUESTIONS ABOVE, OR TO ADD INFORMATION THAT YOU FEEL IS IMPORTANT FOR THE INVESTIGATING DEPUTY TO BE AWARE OF:

PLEASE TYPE/PRINT THE NAMES OF YOUR (4) REFERENCES THAT SIGNED YOUR APPLICATION ALONG WITH THEIR PHONE

NUMBERS:

1. _____, _____
(NAME) (AREA CODE & PHONE #)

2. _____, _____
(NAME) (AREA CODE & PHONE #)

3. _____, _____
(NAME) (AREA CODE & PHONE #)

4. _____, _____
(NAME) (AREA CODE & PHONE #)

HAVE YOU SUCCESSFULLY COMPLETED A 16-HOUR FIREARMS SAFETY COURSE AS PRESCRIBED BY N.Y.S. PENAL LAW?

☐ YES ☐ NO ☐ N/A ***PLEASE ATTACH A COPY OF YOUR COURSE CERTIFICATE***

I, _____, BEING DULY SWORN, SAYS: I HAVE READ THE FORGOING
(TYPE OR PRINT NAME)
QUESTIONS AND THAT THE ANSWERS I HAVE PROVIDED IN RESPONSE TO THEM IS COMPLETE, TRUE, AND ACCURATE.

NOTICE

IT IS A CRIME, PUNISHABLE AS A CLASS A MISDEMEANOR UNDER THE LAWS OF THE STATE OF NEW YORK, FOR A PERSON, IN AND BY A WRITTEN INSTRUMENT, TO KNOWINGLY MAKE A FALSE STATEMENT, OR TO MAKE A STATEMENT WHICH SUCH PERSON DOES NOT BELIEVE TO BE TRUE.

_____, DATE: _____/_____/_____
SIGNATURE (MUST SIGN IN THE PRESENCE OF A NOTARY)

SWORN TO BEFORE ME THIS _____ DAY OF _____, 20_____.

_____
NOTARY PUBLIC

TOMPKINS COUNTY SHERIFF'S OFFICE
SHERIFF DEREK R. OSBORNE
UNDERSHERIFF JENNIFER K. OLIN

NEW YORK

779 Warren Road
Ithaca, NY 14850

Phone
(607) 257-1345

Fax
(607) 266-5436

AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

I, _____, do hereby authorize and grant disclosure of all records concerning myself relevant to my application for a gun permit to the Tompkins County Sheriff's Office, regardless of whether such records are public, private, sealed, or confidential.

The intent of this authorization is to grant my consent to full and complete disclosure of all records concerning myself regarding my application for a gun permit. This includes, but is not limited to; records pertaining to any mental illness history and/or treatment; records related to any police contact; any records related to my past or current employment; any record of my service in the United States Armed Forces in any capacity.

I hereby waive and release any person or agency from any legal action in any jurisdiction for providing information related to me and I hereby release any such person or agency from any and all liability due to providing such information to the Tompkins County Sheriff's Office. I further waive and release the Tompkins County Sheriff's Office from any and all liability and/or legal action in any jurisdiction for collecting, using, or disseminating such information in furtherance of my application for a gun permit.

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I have read and fully understand the contents of this Authorization for Release of Personal Information.

Date of Birth: ____/____/_____ Social Security Number: _____

Signature: _____ Date: ____/____/_____

Sworn to and subscribed before me on this

_____ day of _____, 20_____

_____
Signature and Seal of Notary Public

Tompkins County Mental Health Services
Authorization for Release of Information
(Including Mental Health and Alcohol/Drug Treatment Information)

Client/Patient Name	Date of Birth	Client/Patient ID
Client/Patient Address		

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

1. This authorization may include disclosure of information from FEDERALLY ASSISTED ALCOHOL and DRUG TREATMENT PROGRAMS covered by 42 CFR Part 2 and OMH LICENSED MENTAL HEALTH TREATMENT PROGRAMS covered by NYS Mental Hygiene Law only if I place my initials on the appropriate line in item 9. In the event the health information described below includes these types of information, and I initial the line on the box in Item 9, I specifically authorize release of such information from the persons(s) indicated in Item 5 to the person(s) indicated in Item 6 and, if indicated by checking the "Two-Way Disclosure" box in item 7, also from the person(s) in number 6 to the person(s) in number 5.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of alcohol/drug treatment or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider, Person(s) or Entity Authorized Who Will Disclose this Information:
Tompkins County Mental Health Services

6. Name and Address of Provider, Person(s) or Entity to Whom this Information Will Be Disclosed:
Tompkins County Sheriff's Office and County Court Judges of Tompkins Co.

7. Two-Way Disclosure [X] — I authorize both providers in items 5 and 6 above to disclosed the specified information to each other as needed until this authorization expires or is revoked by me.

8. Purpose for Release of Information: Background Investigation for issuance of a gun permit pursuant to NYS Penal Law 400.00.

9. **For the following to be included, indicate the specific information to be disclosed and initial below.**	Information to be Disclosed	Initials
☐ Health information		
☐ Records from federally assisted Alcohol/Drug treatment programs		
☐ Clinical records from OMH licensed Mental Health programs*		
[X] Other information	Summary of treatment.	

10. If not the client/patient , name of person signing form:	11. Authority to sign on behalf of client/patient:

The information on this form may be disclosed until the date of issuance or denial of a NYS Gun Permit.
All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

☐ Client/Patient declined copy

SIGNATURE OF CLIENT/PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW _____ DATE _____

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the client/patient and/or the client/patient's authorized representative.

WITNESS NAME /TITLE _____ SIGNATURE _____ DATE _____

This form may NOT be used in place of DOH2557 for release of confidential HIV/AIDS information. This form may be used in place of OMH 11 or 11C, and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Information from OMH licenced Mental Health treatment progrmas and federally assisted Alcohol/Drug treatment programs must be accompanied by the required statements regarding prohibition of redisclosure.

*Note: Information from OMH Mental Health treatment program clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for theinformation, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

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:

8. Name and address of person(s) or category of person to whom this information will be sent:

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 History** _____

Include: (*Indicate by Initialing*)

_____ **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 NYS Penal Law 400.00(4)**	
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_____ City_____ State_____

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**