



Schenectady Police Department

531 Liberty Street, Schenectady, NY 12305

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www.schenectadypd.com



Wayne E. Bennett, Public Safety Commissioner

Brian A. Kilcullen, Chief of Police

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Assistant Chief of Police
Investigative Services Bureau

Jack Falvo
Assistant Chief of Police
Field Services Bureau

Michael J. Seber
Assistant Chief of Police
Administrative Services Bureau

The Schenectady Police Department encourages citizens to assist in the investigation of complaints against our officers. The statement you are about to give is necessary to complete an investigation. The Police Department takes all precautions to protect the confidentiality of citizens and statements. However, your name or the information you give may have to be revealed as part of the investigation or in conjunction with any administrative or judicial proceedings.

Once your complaint is filed it will be investigated by the Office of Professional Standards. Once the investigation is complete a written summary and finding is issued.

Your complaint will be thoroughly reviewed at various levels; the OPS Commander, Chief of Police and the Civilian Police Review Board all review and approve each case.

Internal investigations and the review of that investigation, including administering discipline when necessary, is a very time consuming process. Please be patient. At the conclusion of the process you will receive written notice of the findings.

Filing a complaint does not bar the filing of a lawsuit for damages or injury, nor does it bar prosecution for perjury or filing a false instrument.

As the Chief of Police I want to thank you in advance for your cooperation and patience during this process.

Sincerely,

Brian A. Kilcullen

Brian A. Kilcullen
Chief of Police



Schenectady Police Department

Personnel Complaint Form



OPS Case # _____

Date of Report: _____

Time of Report: _____

Complainant: _____ DOB: _____

Address: _____

Phone: (H) _____ W) _____ Other _____

Employer: _____

Address: _____

Date of Incident Complained of: _____ Time: _____

Location of Incident: _____

Standard Incident Report (SIR) Number: _____

Personnel Complained of: (name, badge numbers, car number, or physical description)

Were there witnesses present? If Yes: Witness Information: (name, age, address, phone numbers, employment)

If NO: Check Box

Complaint Received By: Signature: _____

Printed Name: _____

Where Received: _____

Complainants Initials: _____ I can read and write in the English Language.

Complainants Initials: _____ I have personally completed this complaint packet.

Complainants Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPPA

[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 Issuance Portability and Accountability Act of 1996 (HIPPA), 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 the 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 disclosing 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 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 the 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 the person(s) or category of person to whom this information will be sent: Office of Professional Standards Schenectady Police Department 531 Liberty St. Schenectady, NY 12305	
9(a). Specific information to be released:	
<input type="checkbox"/> Medical Record from (insert date) _____ to (insert date) _____	
<input type="checkbox"/> 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.	
<input type="checkbox"/> Other: _____	Include: <i>(Indicate by Initialing)</i> _____ Alcohol/Drug Treatment _____ Mental Health Information _____ HIV-Related Information
Authorization to Discuss Health Information	
(b) <input type="checkbox"/> 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: Schenectady Police Department (Attorney/Firm Name or Governmental Agency Name)	
10. Reason for release of information: <input type="checkbox"/> At request of individual <input type="checkbox"/> Other For Investigation	11. Date or event on which this authorization will expire:
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.