

 <p><b>Bureau of Criminal History Information</b>          NYS Office of Mental Health          44 Holland Avenue          Albany, NY 12229          Telephone No: 518-549-5180          Fax No: 518-549-5188</p>	<p><b>Authorized Person Designation Form</b></p> <p><b>Criminal History Information Tracking System (CHITS)</b></p>	<p><b>Provider Name:</b>  <b>Address:</b></p> <p><b>Agency Code:</b>  <b>Telephone:</b>  <b>Fax:</b></p>
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The purpose of this form is to designate the Authorized Person for your agency\* who is allowed to request, on behalf of your agency, fingerprints and criminal history information checks pursuant to provisions of Chapter 575 of the Laws of 2004. It also requests permissions for this Authorized Person to access the OMH Criminal History Information Tracking System (CHITS).

\* For purposes of this form, the term "agency" means the person or entity that is authorized to request a check of criminal history information pursuant to Section 845-b of the Executive Law.

**INSTRUCTIONS:**

1. Please complete all fields on this form. If the Authorized Person currently uses **any** OMH system (CAIRS, NYISER, etc.), print or type the OMH user ID where indicated.
2. One Authorized Person may be designated on this form. (Please photocopy additional forms as needed.)
3. Authorized Person must sign and date this form where indicated.
4. Please enclose the form(s) in the envelope provided or mail to the Bureau of Criminal History Information at the address above.

**Part 1. Authorized Person (Please Print)**

Last Name:	First Name:	M. I.:	Title:
Work Email Address:	Work Phone #:	OMH User ID (if already assigned):	
Work Address (Street):			
City:	State:	Zip:	

I understand that my access to the Criminal History Information Tracking System (CHITS) is granted for the sole purpose of performing responsibilities related to the request, review and receipt of criminal history summaries pursuant to provisions of Chapter 575 of the Laws of 2004. I agree to use this application solely in support of that responsibility. I further understand that the results of criminal history summaries will only be used and disseminated for purposes authorized by law, and will abide by the confidentiality requirements set forth in this statute.

Signature of Authorized Person: \_\_\_\_\_ Date: \_\_\_\_\_

**Part 2. Provider Approval**

**DIRECTOR OF THE PROVIDER AGENCY MUST APPROVE EACH AUTHORIZED PERSON BY SIGNING BELOW**

I hereby designate the person identified in Part 1 of the form to serve as the Authorized Person for the Provider as noted on this form. I also request access and appropriate permissions for this person to use the Office of Mental Health Criminal History Information Tracking System (CHITS) in support of this responsibility.

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
(Please Print) (Please Print)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_