COUNTY CLERK'S OFFICE
COUNTY OF KINGS
SUPREME COURT BUILDING
360 ADAMS STREET
BROOKLYN, N.Y. 11201

NANCY T. SUNSHINE
COUNTY CLERK
CLERK OF THE SUPREME COURT
COMMISSIONER OF JURORS

To: Treating Physician
From: Commissioner of Jurors, Kings County
Subject Medical Documentation For Jury Exemption

Re: _____

Juror Index #: _____

Effective January 1, 1996, the State of New York eliminated all exemptions from jury duty. Under Section 517 of the New York State Judiciary Law, we are therefore required to thoroughly document all cases in which jurors are excused from jury service for medical reasons. We cannot excuse potential jurors "at their word" and require specific medical documentation to remove a person from the jury pool. The Kings County Clerk's Office has provided a form, on the back of this letter, to simplify your work and satisfy the law's requirements.

If your patient is requesting a medical exemption from jury duty and, in your professional opinion, your patient's medical condition renders him/her incapable of serving as a juror, please complete and return the form on the back of this letter. A HIPPA authorization to provide this information is provided below. The form may be faxed to 1-718-643-2481 or mailed to: Kings County Clerk's Office, 360 Adams Street, Room 156, Brooklyn, New York 11201.

Thank you in advance for your cooperation in this matter.

HIPPA AUTHORIZATION TO RELEASE JUROR MEDICAL INFORMATION:

I authorize that health information regarding my care and treatment be released as set forth herein in accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV RELATED INFORMATION (Human Immunodeficiency Virus that causes AIDS). I specifically authorize release of such information to the Kings County Clerk's Office Division of Jurors only. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand that signing this authorization is voluntary. This authorization shall be valid for six months and will expire six months from the date set forth below.

Dated: _____ Juror's / Patient's Signature: _____

JUROR MEDICAL EXCUSE FORM

Date :_____

Juror's Name:_____ Date of Birth:_____
Juror's Address : _____
Juror's Index # :_____

Stamp Physician's Name & License # : _____

Is the above patient able to perform jury duty? YES _____ NO _____

Detailed diagnosis of mental/physical condition:

_____
_____
_____
_____
_____

Why does this condition prevent jury service? _____
_____

Prognosis of the length of time the condition is expected to continue to exist:

Permanent_____ 6 months _____ 2 years _____ Other _____

Does the person in question work? YES _____ NO _____

Where employed and in what capacity ? _____
_____

(THIS STATEMENT IS MADE AND SIGNED UNDER PENALTY OF PERJURY, PURSUANT TO ARTICLE 210 OF THE NEW YORK STATE PENAL LAW)

Date: _____ _____
(Physician's Signature)

Phone # _____