



Send completed form via email to recordsaccess@health.nyc.gov

Or form can be mailed to:

Records Access Officer
NYC DOHMH
42-09 28th Street, CN-31
Long Island City, NY 11101

Or form can be faxed to:

347-396-6087

For office use only:

CONTROL NUMBER:

Freedom of Information Law Dog Bite Request Form
For use by attorneys, insurance companies, or other third party requesters

Items outlined in red are required fields. Please provide as much information as possible.

Your Name:

Your Address:

Street

City

State

ZIP Code

Your email address:

Your Phone No.:

Your client's name:

Your client's relationship to incident (check one):

Person Bitten

Dog Owner

Other – *Specify relationship to dog owner or person bitten.*

Date of bite:

Address of bite incident:

Street

Borough

Dog's Name:

Dog License #:

Dog Owner's Name (if not your client):

Dog Owner's Address (if not your client):

Street

City

State

ZIP Code

Please attach/include signed authorization.

Written authorization from either person bitten or dog owner is needed to provide unredacted records; dog owners will receive records with person bitten's information redacted.

Please state relationship of person signing authorization to your client (e.g., self, parent, guardian):

Please provide documentation of your relationship to individual or entity to whom authorization was given if not to you or your firm.