TOWN OF COLONIE
DEPARTMENT OF EMERGENCY MEDICAL SERVICES
312 WOLF ROAD
LATHAM, NY 12110

PATIENT'S REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

TO: Town of Colonie Emergency Medical Services Department

I, _____, hereby request copies of my

medical records / medical bills for services occurring on _____.
(Circle one or both) (Date of Call)

Patient Name _____

Mailing Address _____

Phone (H) _____ (W) _____ (Other) _____

Date of Birth _____ Social Security #_____

Please indicate how you would like to receive the protected health information:

___ US Mail ___ Pick-up in-person ___ Inspect records only

_____
Signature of Patient

(Please leave the sections below blank)

To Patient – your request is hereby: ☐ Approved ☐ Denied

Total Charge: $_____
Fee for records is 75¢ per page. Payment is required before records will be provided.

If we deny your request to inspect or copy protected health information, you will receive a written denial that explains the basis for the denial, your rights to have the denial reviewed and an explanation of how to exercise those rights.

For Office Use Only:

Date Request Received _____
Date Request Reviewed _____
Date Records Sent _____

Type of Verification Provided:
___ Photo ID/Driver's License
___ Corresponding Information
___ Other: _____