

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: \_\_\_\_\_