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
Requesting Information for Yourself or Your Child

Items outlined in red are required fields.

Your Name:

Your Address:

Street

City *State* *ZIP Code*

Your Email Address:

Your relationship to incident (check one):

- ☐ Person Bitten
- ☐ Parent of Person Bitten
- ☐ Dog Owner
- ☐ Other – *Specify relationship to dog owner or person bitten. If none given, then only fully redacted documents will be provided.*

Date of bite:

Address of bite incident:

Street

City *State* *ZIP Code*

Dog's Name: ***Dog License #:***

Dog Owner's Name *(if not you):*

Dog Owner's Address *(if not you):*

Street

City *State* *ZIP Code*

Please note that name and contact information of person bitten will not be released to dog owner without authorization from person bitten or his/her parent.

Authorization provided? ☐ *Yes* ☐ *No*