

## Request for Release of Information

**There is a fee of fifty cents per copy and a ten dollar fee for records search over 10 minutes**

Person Requesting the Information: (Print) \_\_\_\_\_ Phone Number \_\_\_\_\_

By my signature below, I acknowledge that I am requesting this information under the Freedom of Information Act (FOIA).

Signature: \_\_\_\_\_

Request Date: \_\_\_\_\_ (Request can take up to 5 days excluding Saturdays, Sundays or Legal Holidays).

Information Requested: \_\_\_\_\_

Facility / Property: \_\_\_\_\_

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### For Health Department Use Only

Start Time: \_\_\_\_\_

End Time: \_\_\_\_\_

Number of Copies: \_\_\_\_\_ x 0.50 = \_\_\_\_\_

Research Time in Hours \_\_\_\_\_ x \$10.00 / hour = \_\_\_\_\_

Employee Name: \_\_\_\_\_