REQUEST FOR RECORDS
WEBER-MORGAN HEALTH DEPARTMENT

Requestor's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime phone number where you can be contacted: _____

Clear description of record sought: _____

_____

_____

☐ I would like to inspect the record.

☐ I would like to receive a copy of the record. I understand that the health department may charge a fee for copies of records including staff time for summarizing, collection, etc. (§63-2-203, Fees), and that copies will be provided subject to fees being paid. I authorize costs up to $_____. If costs are greater than the amount specified, I understand that the health department will contact me for approval prior to processing the request.

Requestor's Signature_____ Date _____

Request Accepted By _____ Date _____

Request Processed By _____ Date _____

Comments: _____

[ ] Requestor notified that the office does not maintain the record. Date _____
[ ] Request for extension of time for extraordinary circumstances. Date _____
[ ] Cost authorization obtained from requestor. Cost $_____ Date _____
[ ] Cost waived. Approved by _____ Date _____

Record Accepted By _____ Date _____

Fees Collected By _____ Date _____

Comments _____

_____