

DISTRICT HEALTH DEPARTMENT # 10

REQUEST FOR DISCLOSURE OF PUBLIC RECORDS

Date of Request: _____

Requester's Name: _____

Phone Number: _____ Fax No: _____

Mail Request to:

Address: _____

City: _____ State: _____ Zip: _____

Specific information being requested. If related to Environmental Health services, please list the following information: **township**, section, **street address**, property ID#, owner's name, and type of record you are requesting.

Date: _____ Signature: _____

Request will normally be processed within five (5) working days.

Note: You will be billed if the actual cost of responding to this request exceeds \$20.

OFFICE USE ONLY

Date request Received: _____

Request Approved By: _____

Date Approved for Released: _____ Date Request Release: _____

Number of Pages Released: _____ Charges: \$ _____

Comments: