Eastern Highlands Health District

4 South Eagleville Road
Mansfield, CT 06268
www.ehhd.org

FREEDOM OF INFORMATION ACT REQUEST

Date:

Name:

Address:

Phone #:

Email:

Please describe with specificity the document(s) you are requesting. If you are not sufficiently specific, we may not be able to identify the document(s) you request which may delay our response to your request:

I want to (please check one):

☐ Review Records at EHHD Office

☐ Receive Hard Copies of Requested Documents (.50 per page)

☐ Other (please specify)

I agree to pay such fees and costs prior to the release of documents to me. I understand that materials may be picked up and payment made at the EHHD Office. I understand that the fees may be waived if I, the requester, am receiving public assistance or can demonstrate other facts showing my inability to pay due to indigence.

Signature of Requester (type your name) _____

Department use only

Date Request Received:_____ Date Picked-Up:_____

Docs. Returned to TC: _____ Date Completed:_____

#of pages: _____ Cost: $_____

Notes:

Revised 8/10/17