MOBILE COUNTY HEALTH DEPARTMENT
Request for Information

To be filled out by person requesting information and returned to the custodian of the requested information and placed in the file from which the requested information was taken. $25.00 must accompany this form.

Date:_____

Name of person requesting information:_____

Address:_____

Phone:_____

Information requested:_____

_____

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Reason requested:_____

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_____

File number or designation (to be filled out by records custodian):_____

_____
(Directorate/Bureau Director)

Date of disclosure:_____