MOBILE COUNTY HEALTH DEPARTMENT
Request for Information

Date:_____

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. **$30.00 must accompany this form**.

Name of person requesting information:_____

Address:_____

Phone:_____

Email address:_____

Information requested:_____

_____

_____

_____

_____

Reason request:

_____

_____

_____

_____

_____

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

_____
(Directorate/Bureau Director)

Date of disclosure:_____