



## PUBLIC RECORDS REQUEST FORM

Date: \_\_\_\_\_

Official or agency requesting information: \_\_\_\_\_  
(Name and address)

\_\_\_\_\_  
(Telephone, fax and email if available)

Person requesting records: \_\_\_\_\_  
(Name and address)

\_\_\_\_\_  
(Telephone, fax and email if available)

Records requested (be specific and attach additional sheets if necessary):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I would like a copy\* of the records.** (Check here.)

\*Standard copy fee for Health and Hospital Corporation: **\$0.25 per page**

(Copies produced in any format other than standard-sized photocopies shall have a fee equal to the direct cost of supplying the information.)

**Please write or call me to advise me of the copy fee prior to mailing or faxing.** (Check here.)

**I would like to inspect the records during normal business hours at the agency and do not wish to obtain a copy at this time (no fee to inspect). Please write or call me to arrange.** (Check here.)

*If my request is denied, under law an official or agency is required to respond in writing and state the statutory exception authorizing the withholding of all or part of the public record and the name and title or position of the person responsible for the denial.*

Please print this form, fill it out and return to: Health and Hospital Corporation  
Public Relations department, 6th floor  
3838 North Rural Street  
Indianapolis, IN 46205  
Phone: 317-221-2463, fax: 317-221-2459

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (mm/dd/yyyy)