ORLEANS COUNTY HEALTH DEPARTMENT

14012 Route 31 West, Albion, NY 14411-9372
Phone (585) 589-3278
Fax (585) 589-2873
www.orleansny.com/publichealth
Licensed Home Care Services Agency

Paul A. Pettit, MSL
Public Health Director

Mary Janet Sahukar, BSN
Director of Patient Services

FOIL REQUEST

Date of Request _____

(Please Print)

Name of Applicant _____

Address _____

Representing _____

Daytime Telephone Number _____

I hereby apply to ☐ inspect and/or ☐ copy the following records:

_____

_____

_____

_____

_____

I understand the Records Access Officer must respond to my request within five business days of receipt of written request by making the records available or by denying access in writing giving the reasons for denial or providing a written acknowledgment of receipt of my request and a statement of the approximate date when the request will be granted.

I also understand and acknowledge that I will be charged a fee of $0.25 per photocopy for documents up to 9" by 14" and a fee of $1.00 for certification. Fees for copies of other records will be based upon the actual cost of reproduction. Payment must be made at the time copies of records are provided.

Signature of Applicant

_____

Return completed application to:

Kimberly Castricone
Orleans County Health Department
14012 Route 31 West
Albion, NY 14411

"Healthy People in a Healthy Community"

For Agency Use Only:

_____ Approved

_____ Denied for reason(s) checked below

_____confidential disclosure

_____part of investigatory files

_____unwarranted invasion of personal privacy

_____record of which this agency is legal custodian cannot be found

_____record is not maintained by this agency

_____exempted by statute other than the Freedom of Information Act

_____other (specify)

_____ _____ _____

signature title date

Receipt:

Number of Copies received: _____ Cost per copy: _____ Total amount due:_____

Cash/Check/Money Order received in the amount of $_____, on this date:_____

Make Checks/Money Order payable to: *Orleans County Health Department*

NOTICE: You have a right to appeal a denial of this application to the head of this agency, who must fully explain his reasons for such denial in writing seven days of receipt of an appeal.

I HEREBY APPEAL:

_____ _____

signature date