RECORDS REQUEST, SUNSHINE LAW – CGCPHC

Cape Girardeau County Public Health Center
1121 Linden St.
P.O. Box 1839
Cape Girardeau, MO 63702-1839

This is a request for records under the Missouri Sunshine Law, Chapter 610, RSMo. The Health Center makes every effort to comply with requests for records and as such will provide you with a response by the end of the third business day (excluding legal holidays and weekends) following the date the request is received. A response constitutes either compliance of the records requested, a reason for delay or explanation as to why the records may not be available as requested.

Fees for copies are based upon the actual hourly rate it takes to research and duplicate the material plus $0.10 per page. Fess for electronic and other reproductions will be based on actual costs plus any duplication time. These fees are payable in advance prior to release. If you believe your request serves the public interest, and is not just for personal or commercial interest, you may ask that fees be waived.

I request that you make available to me the following records: (Describe the records as specifically as possible. In cases where you are asking for records that cover only a particular period, such as last year or a specific month, identify that time period, otherwise the time frame will be considered to be 1 month.)

Description of Records Being Requested:	Time Frame Requesting:

☐ I understand that fees are allowed to be charged for staff time for research of records, copying / scanning or other as needed (t be disclosed). I authorize the Health Center to proceed unless fees exceed the amount of $______________. Please contact me if fees exceed this amount.

☐ I request the fees be waived to serve the public's interest. Please state how and why the info will be used in public interest. ____

____.

Record(s) Requested By: ____
(Please Print) First Name Last Name

____
Address

Email: ______________________________ Phone: ( )______________________________

______________________________ ______________________________
Signature of Person Making Request Date of Request

OFFICE USE ONLY

Disposition of Request:

☐ Approved Date Information Provided: ______________________________

☐ Denied Reason for Denial: ______________________________

______________________________ ______________________________
Signature of Staff Completing Request Date of Completion of Request

***Send signed and completed forms to: board@capecountyhealth.com or mail to address listed above.**