Macon County Mental Health Board

FOIA Request Form

Full Name: _____ Date: _____

Street Address: _____

City:_____ State:_____ Zip Code: _____

Phone: _____ Email: _____

Requested Records (Please be as specific as possible. Use attach additional pages as needed.):

Please check all that apply:

☐ I will view these records in the MCMHB offices during regular business hours.

☐ I would like copies of the requested records (15 cents per page, due before pick up).

☐ Please contact me if the cost exceeds $5.00.

* Policy Agreement

☐ I have read and understand the FOIA policy on mcmhb.com.

Signature: _____ Date: _____

INTERNAL USE ONLY

Date Received:_____ Time Received: _____

Approved as Requested Approved with Changes Not Approved

Signature: _____ Date: _____

Please send completed form to general@mcmhb.com or fax to (217) 423-1035.